

THE 1995 ANNUAL REPORT OF THE BOARD OF
TRUSTEES OF THE FEDERAL HOSPITAL
INSURANCE TRUST FUND



COMMUNICATION

FROM

THE BOARD OF TRUSTEES,
FEDERAL HOSPITAL INSURANCE
TRUST FUND

TRANSMITTING

THE 1995 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE TRUST FUND, PURSUANT TO
SECTION 1817(b) OF THE SOCIAL SECURITY ACT, AS AMENDED



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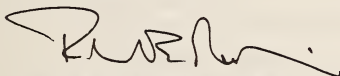
BOARD OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE TRUST FUND
Washington, D.C., April 3, 1995

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Speaker of the House of Representatives
Washington, D.C.

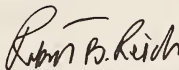
HONORABLE Albert Gore, Jr.
President of the Senate
Washington, D.C.

GENTLEMEN: We have the honor of transmitting to you the 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (the 30th such report), in compliance with the provisions of section 1817(b) of the Social Security Act.

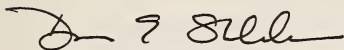
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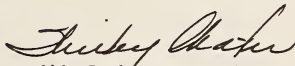
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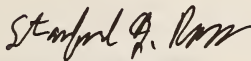
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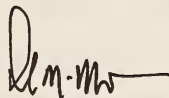
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Stanford G. Ross, *Trustee.*



David M. Walker, *Trustee.*



Bruce C. Vladeck, *Administrator
of the Health Care Financing
Administration, and Secretary,
Board of Trustees.*

CONTENTS

I. OVERVIEW	1
A. Summary	1
1. Operations of the Hospital Insurance Program	1
2. Conclusion of the Board of Trustees	3
B. The Board of Trustees	5
C. Expected Operations and Status of the Trust Fund	5
D. Actuarial Status of the Trust Fund	17
E. Conclusion	26
II. TECHNICAL SECTION	31
A. Social Security Amendments Since the 1994 Report	31
B. Nature of the Trust Fund	31
C. Summary of the Operations of the Trust Fund, Fiscal Year 1994	38
D. Actuarial Methodology and Principal Assumptions for the Hospital Insurance Cost Estimates	43
1. Assumptions	43
2. Program Cost Projection Methodology	43
a. Projection Base	44
b. Payments for Inpatient Hospital Costs	45
c. Skilled Nursing Facility (SNF), Home Health Agency (HHA), and Hospice Costs	50
d. Administrative Expenses	52
3. Financing Analysis Methodology	52
a. Taxable Payroll	52
b. Relationship Between Program Costs and Taxable Payroll	53
4. Sensitivity Testing of Costs Under Alternative Assumptions	54
E. Long-Range Sensitivity Analysis	56
1. Real-Wage Differential	57
2. Consumer Price Index	58
3. Real-Interest Rate	60
4. Health Care Cost Factors	61
III. APPENDICES	63
A. Actuarial Balance Under the Modified Average-Cost Method	63
B. Medicare Incurred Disbursements as a Percent of Gross Domestic Product from Calendar Year 1994 to 2069	66
C. Announcement of the Medicare Part A (Hospital Insurance)	

Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts, for Calendar Year 1995 . .	68
1. Background	68
2. Computing the Inpatient Hospital Deductible for 1995	69
3. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 1995	71
4. Cost to Beneficiaries	71
5. Regulatory Impact Statement	71
D. Announcement of the Medicare Part A (Hospital Insurance) Monthly Premium Rate for the Uninsured Aged and for Certain Disabled Individuals who have Exhausted Other Entitlement, for Calendar Year 1995	73
1. Background	73
2. Premium Amount for 1995	75
3. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Premium Rate	75
4. Costs to Beneficiaries	76
5. Regulatory Impact Statement	76
E. Glossary	78
F. Statement of Actuarial Opinion	93

TABLES

SUMMARY

I.A1. -- Summary of the Financial Status of the HI Trust Fund	3
---	---

EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND

I.C1. -- Operations of the HI Trust Fund During Fiscal Years 1970-2004	8
I.C2. -- Operations of the HI Trust Fund During Calendar Years 1970-2004	10
I.C3. -- Estimated Operations of the HI Trust Fund During Calendar Years 1994-2004, Under Alternative Sets of Assumptions	13
I.C4. -- Ratio of Assets in the Fund at the Beginning of the Year to Disbursements During the Year for the HI Trust Fund	15

ACTUARIAL STATUS OF THE TRUST FUND

I.D1. -- Cost of the HI Program, Expressed as a Percent of Taxable Payroll	19
I.D2. -- Cost and Income Rates of the HI Program, Expressed as a Percent of Taxable Payroll	20
I.D3. -- Actuarial Balances of the HI Program, Under Three Sets of Assumptions	22
I.D4. -- Change in the 75-Year Actuarial Balance Since the 1994 Report	26

NATURE OF THE TRUST FUND

II.B1. -- Contribution Rates and Maximum Taxable Amount of Annual Earnings	33
---	----

SUMMARY OF THE OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1994

II.C1. -- Statement of Operations of the HI Trust Fund During Fiscal Year 1994	38
II.C2. -- Comparison of Actual and Estimated Operations of the HI Trust Fund, Fiscal Year 1994	41

II.C3. -- Assets of the HI Trust Fund, by Type, at the End of Fiscal Years 1993 and 1994	42
---	----

ACTUARIAL METHODOLOGY AND PRINCIPAL ASSUMPTIONS FOR THE HOSPITAL INSURANCE COST ESTIMATES

II.D1. -- Components of Historical and Projected Increases in HI Inpatient Hospital Payments	47
II.D2. -- Relationship Between Increases in HI Program Expenditures and Increases in Taxable Payroll	51
II.D3. -- Summary of Alternative Projections for the HI Program	53

LONG-RANGE SENSITIVITY ANALYSIS

II.E1. -- Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates With Various Real-Wage Assumptions	58
II.E2. -- Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates With Various CPI-Increase Assumptions	59
II.E3. -- Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates With Various Real-Interest Assumptions	60
II.E4. -- Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates With Various Health Care Cost Growth Rate Assumptions	62

ACTUARIAL BALANCE UNDER ALTERNATIVE ASSUMPTIONS AND METHODS

III.A1. -- Actuarial Balances of the HI Program, Under Alternative Sets of Assumptions (Modified Average-Cost Method)	65
---	----

MEDICARE INCURRED DISBURSEMENTS AS A PERCENT OF GROSS DOMESTIC PRODUCT FROM CALENDAR YEAR 1994 TO 2069

III.B1. -- Hospital and Supplementary Medical Insurance Incurred Disbursements as a Percent of Gross Domestic Product	66
---	----

FIGURES

1. Short-Term HI Trust Fund Ratios	16
2. HI Trust Fund Balance, End-of-Year	17
3. Estimated HI Costs and Income Rates	25

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I. OVERVIEW

A. SUMMARY

1. Operations of the Hospital Insurance Program

The hospital insurance (HI) program pays for inpatient hospital care and other related care for those age 65 and over, and for the long-term disabled. In calendar year 1994, HI covered about 32 million aged and about 4 million disabled enrollees at a cost of \$104.5 billion. Of this amount, \$103.3 billion was for benefit payments and \$1.3 billion, 1.2 percent of total disbursements, was for administrative expenses.

The HI program is financed primarily by payroll taxes, with the taxes paid by current workers and their employers used mainly to pay benefits for current beneficiaries. Income not currently needed to pay benefits and related expenses is held in the HI trust fund. The assets of the fund may not be used for any other purpose. While in the fund, the assets are invested in certain interest-bearing obligations of the United States Government. These obligations are backed by the full faith and credit of the U.S. Government.

The payroll taxes of 141 million workers and their employers, amounting to \$95.3 billion or 87.0 percent of total income to the fund, were collected during calendar year 1994. Interest income from investments held by the trust fund amounted to 9.7 percent of total income. The remaining 3.3 percent of calendar year 1994 income consisted mostly of income from the taxation of OASDI benefits, a transfer from the railroad retirement program, transfers to and from the general fund of the Treasury, and premiums paid by voluntary enrollees.

The HI contribution rates applicable to taxable earnings are 1.45 percent for employees and employers, each, and 2.90 percent for self-employed workers. For 1994 and later, the maximum taxable annual earnings amount has been eliminated. Therefore, the HI contribution rates are applicable to all earnings in covered employment.

The adequacy of the HI program's scheduled financing to support program costs in the future is examined under three alternative sets of assumptions: low cost, intermediate, and high cost. The intermediate set of assumptions represents the Trustees' best estimate of the expected future economic and demographic trends that will affect the financial status of the program. The low cost alternative is a more optimistic set of assumptions from the

Overview

standpoint of HI financing and the high cost alternative is a more pessimistic set of assumptions. The trust fund ratio, defined as the ratio of assets at the beginning of the year to disbursements during the year, was 122 percent in 1994. Under all three sets of assumptions, this ratio is projected to decline steadily until the fund is completely exhausted. Under the intermediate assumptions, the trust fund ratio is projected to be exhausted in 2002. Under the high cost and low cost assumptions, the fund would be exhausted in 2001 or 2006, respectively. These projections clearly demonstrate that under a range of plausible economic and demographic assumptions the HI program is severely out of financial balance in the short-range.

Based on the financial projections developed for this report, the Trustees apply an explicit test of short-range financial adequacy. The HI trust fund fails this test by a wide margin. In particular, the trust fund is projected to become insolvent within the next 6 to 11 years under all three sets of assumptions.

The adequacy of current law financing for the HI program in the long-range is measured by comparing tax income year-by-year with the corresponding incurred costs of the program, expressed as percentages of taxable payroll. In addition, the financial status of the program is often summarized, over a specific projection period, by a single measure known as the actuarial balance. The actuarial balance is defined to be the difference between the present value of future program income for the valuation period and the present value of future program costs, where both are expressed as a percentage of future taxable payroll. The "Actuarial Status of the Trust Fund" (section I.D) describes the method used to calculate the actuarial balance in more detail.

Based on the actuarial balance, the Trustees apply a formal test of long-range close actuarial balance. The HI trust fund does not meet the long-range test, as discussed in section I.D, by a wide margin.

Table I.A1 presents a comparison of the projected experience contained in the 1994 and 1995 reports. As this table indicates, the projections in the 1995 report show that the fund would be depleted slightly later than projected in the 1994 report under all three sets of assumptions. The major reason for this difference is a change in the average complexity of hospital services assumed for the future, as described in the technical section of this report. Section I.D discusses in more detail the reasons for the change in the actuarial balance. Compared to last year's report, under the Trustees' intermediate assumptions,

the date of exhaustion is one year later and the 75-year actuarial balance is improved by 0.62 percent of taxable payroll.

Table I.A1. -- SUMMARY OF THE FINANCIAL STATUS OF THE HI TRUST FUND

Set of assumptions	Year in which the trust fund is exhausted as published in the		75-year actuarial balance of the HI program as published in the	
	1994 report	1995 report	1994 report	1995 report
Intermediate	2001	2002	-4.14%	-3.52%
Low cost	2004	2006	-1.31	-1.03
High cost	2000	2001	-9.26	-8.04

2. Conclusion of the Board of Trustees

Under the Trustees' intermediate assumptions, the present financing schedule for the HI program is sufficient to ensure the payment of benefits only over the next 7 years. As a result, the HI trust fund does not meet the Trustees' short-range test of financial adequacy. Under the high cost alternative, the fund is projected to be exhausted in 2001, approximately 6 years from the present. Under the low cost alternative, the trust fund is projected to be exhausted in 2006.

Currently about four covered workers support each HI enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of that century, only about two covered workers will support each enrollee. Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, but under all the sets of assumptions, the trust fund is projected to become exhausted even before the major demographic shift begins to occur.

The Trustees note that some steps have been taken to reduce the rate of growth in payments to hospitals, including the implementation of the prospective payment system for most hospitals. Experience to date suggests that this reimbursement mechanism, together with payment limitation provisions enacted by the Congress, has helped to constrain the growth in hospital payments and has improved the efficiency of the hospital industry.

Overview

Extension of this payment system to other providers of HI services and further legislation to limit payment increases to all HI providers could postpone the depletion of the HI trust fund for about another 5 to 10 years. Much more substantial steps would be required, however, to prevent trust fund depletion beyond 2010 when the baby boom generation begins to reach age 65.

Under present law, as shown by the projections in this report, HI program costs are expected to far exceed revenues over the 75-year long-range period under any reasonable set of assumptions. As a result, the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program.

The cost of the HI program is projected to increase from 1.6 percent of gross domestic product in calendar year 1994 to 4.4 percent of GDP in 2065. This rapid growth is attributable primarily to anticipated increases in hospital admissions and in the complexity of the services provided, together with expected changes in demographics. With the magnitude of the projected actuarial deficit in the HI program and the high probability that the HI trust fund will be exhausted in less than 11 years, the Trustees urge the Congress to take additional actions designed to control HI program costs and to address the projected financial imbalance in both the short-range and the long-range through specific program legislation as part of broad-based health care reform. The Trustees believe that prompt, effective, and decisive action is necessary.

To facilitate this effort, the Trustees further recommend legislation to reestablish the Quadrennial Advisory Council for the Medicare program. This action would help provide critical information that will be needed by the Administration and the Congress as they deliberate the future of the HI program and would help ensure that such information will be available in time to assist the orderly development of legislative solutions. The Trustees believe that prompt action on reestablishing the Advisory Council will help to expedite the legislative process and lead to effective solutions to the short-range and long-range financial problems of the HI program.

B. THE BOARD OF TRUSTEES

The Federal Hospital Insurance Trust Fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1817(b) of the Social Security Act, as amended. The Board is composed of six members, four of whom serve automatically by virtue of their positions in the Federal Government: the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, and the Commissioner of Social Security. The President nominated and the Senate confirmed Stanford G. Ross and David M. Walker to be the other two members, who serve as representatives of the public. The terms of Mr. Ross and Mr. Walker began on October 2, 1990, and expire immediately after the publication of this report. The Commissioner of Social Security became a member of the Board effective March 31, 1995, under Public Law 103-296, approved August 15, 1994.

By law, the Secretary of the Treasury is designated as the Managing Trustee, and the Administrator of the Health Care Financing Administration is designated as Secretary of the Board. The Board of Trustees reports to the Congress each year on the operations and status of the trust fund, in compliance with section 1817(b)(2) of the Social Security Act. This annual report, for 1995, is the 30th such report.

C. EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND

Table I.C1 shows the expected operations of the HI trust fund during fiscal years 1995 to 2004, together with the past experience of the program. The estimates shown in this table are based on the intermediate set of assumptions. The assumptions underlying the intermediate projections are presented in the technical section of this report.

As noted previously, the primary source of financing for the HI program is the payroll tax on covered earnings paid by employees, employers, and self-employed workers. HI payroll taxes amounted to just over \$92 billion in fiscal year 1994.

A new source of financing for the HI trust fund was added as a result of the Omnibus Budget Reconciliation Act of 1993. This legislation increased the maximum proportion of Old-Age, Survivors, and Disability Insurance (OASDI) benefits subject to Federal income taxes from 50 percent to 85

Overview

percent. It further specified that the additional revenues resulting from the change were to be credited to the HI trust fund. (Income taxes on the first 50 percent of OASDI benefits are credited to the OASDI trust funds.)

Income is also received through a financial interchange between the railroad retirement program and the HI trust fund, under the provisions of the Railroad Retirement Act.

A portion of the income to the trust fund is appropriated from general revenue to reimburse the program for the cost of providing HI benefits to certain noninsured persons. Premium income for other noninsured persons, who may enroll in the HI program on a voluntary basis, is estimated based on projected premium rates calculated according to statute and estimated average enrollment.

Additional transfers are made from general revenue to reimburse the HI trust fund for the costs associated with certain military wage credits, as described in the technical section.

The investment of new assets received during fiscal years 1995-2004 is assumed to be in the form of special public-debt obligations bearing interest rates ranging from 6.375 percent to 8 percent, payable semiannually. The average effective annual rate of interest on the assets held by the HI trust fund on September 30, 1994, was 8.4 percent.

Disbursements for benefits are projected to increase in fiscal years 1995-2004, primarily as a result of the increase in hospital payment rates and hospital admissions under the program. The expenditures for benefit payments shown in Table I.C1 differ somewhat from those shown in the President's proposed 1996 Federal Budget. These estimates are based on more recent demographic and economic projections, and they do not reflect the implementation of proposed changes in regulations which were included in the budget. The expenditures for benefit payments shown in this section are based on the assumption that for fiscal years 1996 and later, the prospective payment rates will be increased in accordance with Public Law 103-66, the Omnibus Budget Reconciliation Act of 1993; for fiscal year 1995, the prospective payment rates have already been determined in accordance with the same statute.

The actual operations of the HI program are organized, in general, on a calendar year basis. Earnings subject to taxation and the applicable tax rates are established by calendar year, as are the inpatient hospital deductible and

other cost-sharing amounts. The projected operations of the trust fund on a calendar year basis are shown in Table I.C2, according to the same assumptions as used in Table I.C1.

TABLE I.C1.—OPERATIONS OF THE HI TRUST FUND DURING FISCAL YEARS 1970-2004
(In millions)

Fiscal year ¹	Income					Disbursements			Trust fund				
	Payroll taxes	Income from taxation of benefits	Railroad retirement / account transfers	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other income ²	Total income	Benefits payments ³	Administrative expenses ⁴	Total disbursements	Net increase in fund	Fund at end of year
Historical Data:													
1970	\$4,785	--	\$64	\$617	--	\$11	\$137	\$5,614	\$4,804	\$149	\$4,953	\$661	\$2,677
1975	11,291	--	132	481	\$6	48	609	12,568	10,353	259	10,612	1,956	9,870
1980	23,244	--	244	697	17	141	1,072	25,415	23,790	497	24,288	1,127	14,490
1985	46,490	--	371	766	38	86	3,182	50,933	47,841	813	48,654	4,103 ⁵	21,277
1986	53,020	--	364	566	40	-714 ⁶	3,167	56,442	49,018	667	49,685	17,370 ⁷	38,648
1987	57,820	--	368	447	40	94	3,982	62,751	49,967	836	50,803	11,949	50,596
1988	61,901	--	364	475	42	80	5,148	68,010	52,022	707	52,730	15,281	65,877
1989	67,527	--	379	515	42	86	6,567	75,116	57,433	805	58,238	16,878	82,755
1990	70,655	--	367	413	113	107	7,908	79,563	65,912	774	66,687	12,876	95,631
1991	74,655	--	352	605	367	-1,011 ⁸	8,969	83,938	68,705	934	69,638	14,299	109,930
1992	80,978	--	374	621	484	86	10,133	92,677	80,784	1,191	81,974	10,703	120,633
1993	83,147	--	400	367	622	81	12,484 ⁹	97,101	90,738	866	91,604	5,497	126,131
1994	92,028	1,639	413	506	852	80	10,676	106,195	101,535	1,235	102,770	3,425	129,555
Intermediate Estimates:													
1995	99,748	3,757	408	462	945	67	10,797	116,184	110,284	1,197	111,481	4,703	134,258
1996	105,892	3,891	418	422	1020	-254 ¹⁰	10,988	122,377	121,086	1,252	122,332	45	134,303
1997	111,188	4,154	419	264	1111	64	10,754	127,954	131,607	1,330	132,937	-4,983	129,320
1998	116,963	4,444	420	206	1208	63	10,127	133,431	142,335	1,408	143,743	-10,312	119,008
1999	122,654	4,738	422	168	1315	59	9,067	138,423	153,783	1,490	155,273	-16,850	102,158
2000	128,875	5,058	422	151	1430	59	7,464	143,457	165,983	1,578	167,561	-24,104	78,054
2001	135,951	5,412	427	148	1551	60	5,331	148,880	179,310	1,674	180,984	-32,104	45,950
2002	143,477	5,806	432	137	1692	60	2,633	154,237	193,556	1,775	195,331	-41,094	4,856
2003	151,662	6,245	438	126	1836	60	-671	159,696	208,827	1,884	210,711	-51,015	-46,159
2004	160,507	6,722	446	127	1991	61	-3,985	165,869	225,167	2,001	227,168	-61,299	-107,458

- ¹Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.
- ²Other Income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and a small amount of miscellaneous income.
- ³Includes costs of Peer Review Organizations (beginning with the implementation of the Prospective Payment System on October 1, 1983).
- ⁴Includes costs of experiments and demonstration projects.
- ⁵Includes repayment of loan principal from the OASI trust fund of \$1,824 million.

- ⁶Includes the lump sum general revenue adjustment of -\$805 million, as provided for by section 151 of P.L. 98-21.
- ⁷Includes repayment of loan principal from the OASI trust fund of \$10,613 million.
- ⁸Includes the lump sum general revenue adjustment of -\$1,100 million, as provided for by section 151 of P.L. 98-21.
- ⁹Includes \$1,805 million transfer from the SMI catastrophic coverage reserve fund, as provided for by P.L. 102-394.
- ¹⁰Includes -\$319 million preliminary estimate of the lump sum general revenue adjustment provided for by section 151 of P.L. 98-21.

NOTE: Totals do not necessarily equal the sums of rounded components. Estimates shown for 2003 and later are hypothetical, since the HI trust fund would be exhausted in those years.

TABLE I.C2.-OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1970-2004
(In millions)

Calendar year	Income					Disbursements					Trust fund		
	Payroll taxes	Income from taxation of benefits	Railroad retirement account transfers	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other income ¹	Total income	Benefits payments ²	Administrative expenses ³	Total disbursements	Net increase in fund	Fund at end of year
Historical Data:													
1970	\$4,981	-	\$66	\$863	--	\$11	\$158	\$5,979	\$5,124	\$157	\$5,281	\$698	\$3,202
1975	11,502	-	138	621	\$7	48	664	12,980	11,315	266	11,581	1,399	10,517
1980	23,848	-	244	697	18	141	1,149	26,097	25,064	512	25,577	521	13,749
1985	47,576	-	371	766	41	-719 ⁴	3,362	51,397	47,580	834	48,414	4,808 ⁵	20,499
1986	54,583	-	364	566	43	91	3,619	59,267	49,758	664	50,422	19,458 ⁶	39,957
1987	58,648	-	368	447	38	94	4,469	64,064	49,496	793	50,289	13,775	53,732
1988	62,449	-	364	475	41	80	5,830	69,239	52,517	815	53,331	15,908	69,640
1989	68,369	-	379	515	55	86	7,317	76,721	60,011	792	60,803	15,918	85,558
1990	72,013	-	367	413	122	-993 ⁷	8,451	80,372	66,239	758	66,997	13,375	98,933
1991	77,851	-	352	605	432	89	9,510	88,839	71,549	1,021	72,570	16,269	115,202
1992	81,745	-	374	621	522	86	10,487	93,836	83,895	1,121	85,015	8,821	124,022
1993	84,133	-	400	367	675	81	12,531 ⁸	98,187	93,487	904	94,391	3,796	127,818
1994	95,280	1,639	413	506	907	80	10,745	109,570	103,282	1,263	104,545	5,025	132,844
Intermediate Estimates:													
1995	100,958	3,757	408	462	952	-252 ⁹	11,099	117,384	112,741	1,198	113,939	3,445	136,289
1996	107,208	3,891	418	422	1,042	65	11,098	124,144	123,740	1,271	125,011	-867	135,422
1997	112,606	4,154	419	264	1,134	64	10,698	129,339	134,200	1,350	135,550	-6,211	129,211
1998	118,333	4,444	420	206	1,233	63	9,895	134,594	145,098	1,428	146,526	-11,932	117,279
1999	124,074	4,738	422	168	1,342	59	8,593	139,396	156,727	1,510	158,237	-18,841	98,438
2000	130,569	5,058	422	151	1,459	59	6,744	144,460	169,181	1,600	170,781	-26,321	72,117
2001	137,773	5,412	427	148	1,582	60	4,339	149,741	182,773	1,699	184,472	-34,731	37,386
2002	145,416	5,806	432	137	1,728	60	1,320	154,899	197,226	1,801	199,027	-44,128	-6,742
2003	153,770	6,245	438	126	1,872	60	-2,133	160,378	212,790	1,912	214,702	-54,324	-61,066
2004	162,691	6,722	446	127	2,030	61	-5,809	166,268	229,384	2,031	231,415	-65,147	-126,213

- ¹Other Income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and a small amount of miscellaneous income.
- ²Includes costs of Peer Review Organizations (beginning with the implementation of the Prospective Payment System on October 1, 1983).
- ³Includes costs of experiments and demonstration projects.
- ⁴Includes the lump sum general revenue adjustment of -\$805 million, as provided for by section 151 of P.L. 98-21.
- ⁵Includes repayment of loan principal from the OASI trust fund of \$1,824 million.

⁶Includes repayment of loan principal from the OASI trust fund of \$10,613 million.

⁷Includes the lump sum general revenue adjustment of -\$1,100 million, as provided for by section 151 of P.L. 98-21.

⁸Includes \$1,805 million transfer from the SMI catastrophic coverage reserve fund, as provided for by P.L. 102-394.

⁹Includes -\$319 million preliminary estimate of the lump sum general revenue adjustment provided for by section 151 of P.L. 98-21.

NOTE: Totals do not necessarily equal the sums of rounded components. Estimates shown for 2002 and later are hypothetical, since the HI trust fund would be exhausted in those years.

Since future economic, demographic, and health care usage and cost experience may differ considerably from the intermediate assumptions on which the cost estimates were based, projections have also been prepared on the basis of two different sets of assumptions labeled "Low Cost" and "High Cost." The assumptions used in preparing projections under the low cost and high cost alternatives, as well as under the intermediate assumptions, are discussed in the technical section of this report.

The three sets of assumptions were selected in order to illustrate the sensitivity of program costs to different economic and demographic trends, and to provide an indication of the uncertainty associated with financial projections for the HI program. The low cost and high cost alternatives provide for a fairly wide range of possible experience. While actual experience may be expected to fall within the range, no assurance can be made that this will be the case, particularly in light of the wide variations in experience that have occurred since the beginning of the program.

The estimated operations of the HI trust fund during calendar years 1994-2004, on a cash basis for all program income and disbursements, are summarized in Table I.C3 for all three alternatives. The trust fund ratio, defined as the ratio of assets at the beginning of the year to disbursements during the year, was 122 percent in 1994 and then under the intermediate assumptions is projected to decline steadily until the fund is completely exhausted in 2002. Under the low cost alternative, the trust fund would be exhausted in 2006, while under the high cost alternative exhaustion would occur in 2001. These projections do not reflect any reduction in disbursements due to proposed changes in legislation or regulation which were included in the 1996 Federal Budget but which have not been enacted or implemented.

Projected trust fund operations are shown beyond the point of asset depletion, to indicate the trends in future income and expenditures and to help illustrate the magnitude of the future deficits.¹ It is important to remember, however,

¹ These hypothetical fund operations are estimated based on an underlying assumption that the HI trust fund could *borrow* amounts from the general fund of the Treasury on the same terms that it normally *lends* reserve assets to the general fund (through the purchase of special-issue Treasury securities.) Thus, the hypothetical, post-depletion operations of the trust fund are calculated on a mirror-image basis to the normal investment procedures.

that under present law there is no authority to pay hospital insurance benefits if the assets of the HI trust fund are depleted.

The projections in table I.C3 indicate that without corrective legislation the assets of the HI trust fund would probably be exhausted within the next 6 to 11 years. The fact that exhaustion would occur under a broad range of future economic conditions, and is expected to occur in the relatively near future, indicates the urgency of addressing the HI trust fund's financial imbalance.

**TABLE I.C3. -- ESTIMATED OPERATIONS OF THE HI TRUST FUND DURING
CALENDAR YEARS 1994-2004, UNDER ALTERNATIVE SETS OF ASSUMPTIONS**
(Dollar amounts in billions)

Calendar year	Total income	Total disbursements	Net increase in fund	Fund at end of year	Ratio of assets to disbursements ¹ (percent)
INTERMEDIATE:					
1994 ²	\$109.6	\$104.5	\$5.0	\$132.8	122
1995	117.4	113.9	3.4	136.3	117
1996	124.1	125.0	-0.9	135.4	109
1997	129.3	135.6	-6.2	129.2	100
1998	134.6	146.5	-11.9	117.3	88
1999	139.4	158.2	-18.8	98.4	74
2000	144.5	170.8	-26.3	72.1	58
2001	149.7	184.5	-34.7	37.4	39
2002	154.9	199.0	-44.1	-6.7 ³	19
2003	160.4	214.7	-54.3	-61.1 ³	-3
2004	166.3	231.4	-65.1	-126.2 ³	-26
LOW COST:					
1994 ²	\$109.6	\$104.5	\$5.0	\$132.8	122
1995	117.5	113.8	3.7	136.5	117
1996	125.7	123.6	2.1	138.6	110
1997	132.1	132.8	-0.7	137.9	104
1998	138.9	142.3	-3.4	134.5	97
1999	145.5	152.1	-6.6	127.9	88
2000	152.4	162.3	-9.9	118.0	79
2001	159.3	172.8	-13.5	104.5	68
2002	166.1	183.3	-17.2	87.3	57
2003	173.1	194.2	-21.0	66.3	45
2004	180.5	205.4	-25.0	41.3	32
HIGH COST:					
1994 ²	\$109.6	\$104.5	\$5.0	\$132.8	122
1995	117.7	114.0	3.7	136.5	117
1996	121.8	125.7	-3.9	132.6	109
1997	127.2	138.9	-11.7	120.8	95
1998	134.4	154.3	-19.9	100.9	78
1999	137.0	168.5	-31.5	69.5	60
2000	141.0	184.9	-43.9	25.5	38
2001	146.7	204.9	-58.2	-32.7 ⁴	12

TABLE I.C3. -- ESTIMATED OPERATIONS OF THE HI TRUST FUND DURING CALENDAR YEARS 1994-2004, UNDER ALTERNATIVE SETS OF ASSUMPTIONS
(Dollar amounts in billions)

Calendar year	Total income	Total disbursements	Net increase in fund	Fund at end of year	Ratio of assets to disbursements ¹ (percent)
2002	151.1	225.6	-74.5	-107.1 ⁴	-14
2003	155.3	248.2	-92.8	-200.0 ⁴	-43
2004	159.6	272.7	-113.0	-313.0 ⁴	-73

¹Ratio of assets in the fund at the beginning of the year to disbursements during the year.

²Figures for 1994 represent actual experience.

³Estimates for 2002 and later are hypothetical, since the HI trust fund would be exhausted in those years.

⁴Estimates for 2001 and later are hypothetical, since the HI trust fund would be exhausted in those years.

NOTE: Totals do not necessarily equal the sums of rounded components. Based on the low cost assumptions, assets would be depleted in 2006, just beyond the end of the short-range projection period.

In order to meet the Trustees' test of financial adequacy in the short-range projection period, the HI trust fund ratio must either (a) be at least 100 percent throughout the 10-year projection period, or (b) reach a level of 100 percent within 5 years and remain at or above 100 percent throughout the remainder of the 10-year period. In addition, the fund's estimated assets at the beginning of each month of the 10-year period must be sufficient to cover that month's estimated disbursements. This test is applied to the estimates under the intermediate assumptions for the period 1995-2004. Failure of the trust fund to meet this test is an indication that the solvency of the program over the next 10 years is in question and that action is needed to improve the short-range financial adequacy of the program. As can be seen from Table I.C3, this short-range test is not met. Under the intermediate assumptions, the trust fund ratio falls below the 100-percent level in about 2 years and is exhausted in 7 years.

The ratios of assets in the HI trust fund at the beginning of each calendar year to total disbursements during that year are shown in Table I.C4 for all past years since the beginning of the program. Figure 1 shows these historical trust fund ratios for recent years and the projected ratios under the three sets of assumptions. Figure 2 shows end-of-year trust fund balances for recent historical years and for projected years under the three sets of assumptions. On both figures, the labels "I," "II," and "III" indicate projections under the low cost, intermediate, and high cost alternatives, respectively.

**TABLE I.C4. -- RATIO OF ASSETS IN THE FUND AT THE BEGINNING OF THE YEAR
TO DISBURSEMENTS DURING THE YEAR FOR THE HI TRUST FUND**
(In percent)

Calendar year	Ratio
1967	28%
1968	25
1969	43
1970	47
1971	54
1972	47
1973	40
1974	69
1975	79
1976	77
1977	66
1978	57
1979	54
1980	52
1981	45
1982	52
1983	20
1984	29
1985	32
1986	41
1987	79
1988	101
1989	115
1990	128
1991	136
1992	136
1993	131
1994	122

Figure 1. SHORT-TERM HI TRUST FUND RATIOS

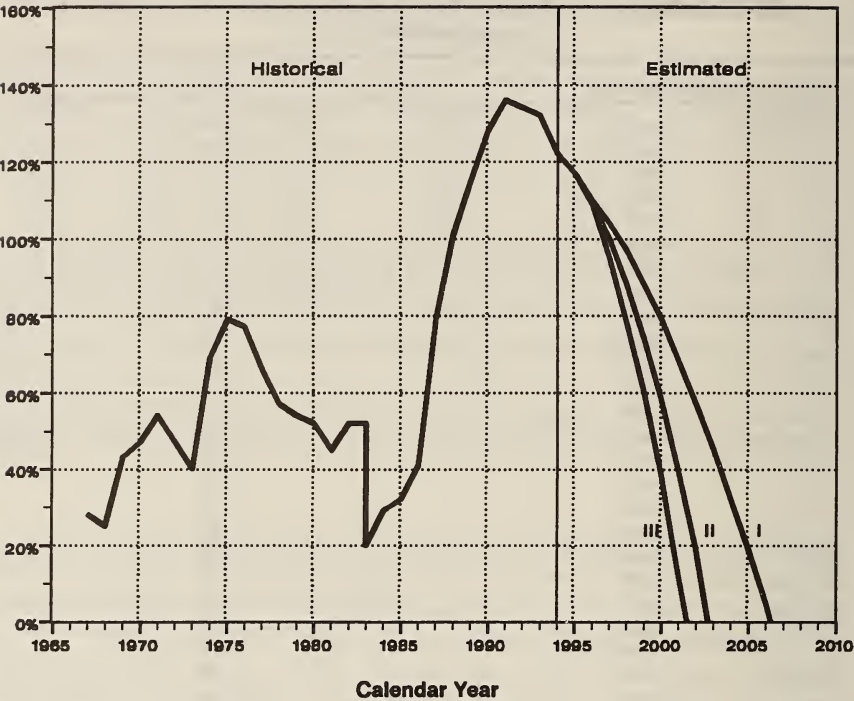
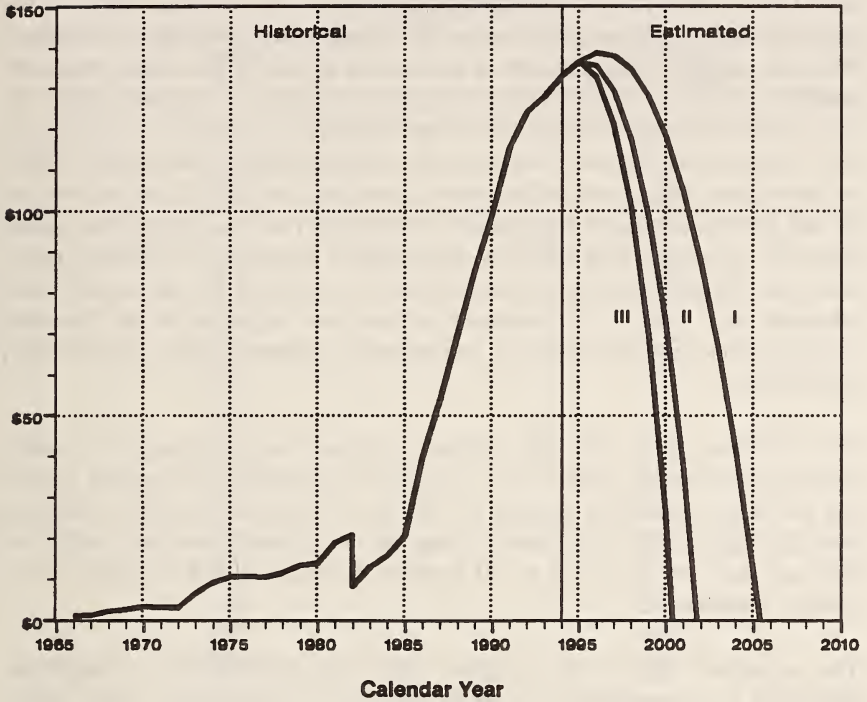


Figure 2. HI TRUST FUND BALANCE, END-OF-YEAR (In \$ Billions)



D. ACTUARIAL STATUS OF THE TRUST FUND

In the previous section (I.C) entitled "Expected Operations and Status of the Trust Fund", the expected operations of the HI program over the next 10 years were presented. In this section, the actuarial status of the trust fund, or the adequacy of the scheduled financing to support program costs well into the future, is examined under all three alternative assumptions. The assumptions used in preparing projections are summarized in the technical section.

The adequacy of the current law financing schedule for the HI program in the long-range is measured by comparing on a year-by-year basis the income rates (from payroll taxes and income from taxation of OASDI benefits) with the corresponding incurred costs of the program, expressed as percentages of taxable payroll. If these two items were exactly equal in each year of the

projection period and all projection assumptions were realized, then revenues would be sufficient to provide for program costs. In practice, however, tax rate schedules, which make up most of the income rate, generally are designed with rate changes occurring only at intervals of several years, rather than with continual yearly increases to match exactly with projected cost increases. To the extent that small differences between the yearly costs of the program and the corresponding income rates occur for short periods of time and are offset by subsequent differences in the reverse direction, the financing objectives can be met by maintaining an appropriate contingency reserve. In projecting costs under the program, only incurred expenditures (benefits and administrative costs) attributable to insured beneficiaries are considered, since benefits and administrative costs for noninsured persons are expected to be financed through general revenue transfers and premium payments rather than through payroll taxes.

The historical costs of the HI program, expressed as percentages of taxable payroll, are shown in Table I.D1. The ratio of expenditures to taxable payroll has increased from 0.94 percent in 1967 to 3.16 percent in 1994, reflecting both the higher rate of increase in program costs than in earnings subject to HI taxes and the extension of HI benefits to disabled and end-stage renal disease beneficiaries.

The projected costs of the program under the intermediate assumptions, expressed as percentages of taxable payroll, and the income rates under current law for selected years over the 75-year period 1995-2069, are shown in Table I.D2. Further increases in the ratio of expenditures to taxable payroll under the intermediate assumptions result from the projection that the cost of the HI program will continue to increase at a higher rate than taxable earnings, as discussed later in this section. It can be seen from the selected years shown in Table I.D2 that, on a year-by-year basis, the income rates under current law are insufficient by a large margin to support the projected costs of the current program. As a result, the program is severely out of financial balance and substantial measures will be required to increase revenues and/or reduce expenditures.

TABLE I.D1. -- COST OF THE HI PROGRAM, EXPRESSED AS A PERCENT OF TAXABLE PAYROLL

Calendar year	Expenditures under the program ¹
1967	0.94%
1968	1.04
1969	1.12
1970	1.20
1971	1.32
1972	1.30
1973	1.33
1974	1.42
1975	1.69
1976	1.83
1977	1.95
1978	2.01
1979	1.99
1980	2.20
1981	2.39
1982	2.65
1983	2.67 ²
1984	2.64
1985	2.63
1986	2.55
1987	2.45
1988	2.42
1989	2.66
1990	* 2.71
1991	2.77
1992	2.98
1993	3.21
1994	3.16

¹Estimated costs attributable to insured beneficiaries only, on an incurred basis. Benefits and administrative costs for noninsured persons are expected to be financed through general revenue transfers and premium payments, rather than through payroll taxes. Gratuitous credits for military service after 1956 are included in taxable payroll.

²Deemed credits for military service before 1984 were attributed to the year in which such service had occurred. If all such credits had been attributed in 1983, expenditures under the program in 1983 would have been lower by 0.18 percent of taxable payroll.

TABLE I.D2. -- COST AND INCOME RATES OF THE HI PROGRAM, EXPRESSED AS A PERCENT OF TAXABLE PAYROLL ¹

Calendar year	Cost rates ²	Income rates	Difference ³
1995	3.26%	3.01%	-0.25%
2000	3.77	3.02	-0.75
2005	4.17	3.03	-1.14
2010	4.57	3.05	-1.52
2015	5.15	3.09	-2.06
2020	5.87	3.13	-2.74
2025	6.70	3.18	-3.52
2030	7.52	3.21	-4.31
2035	8.13	3.24	-4.89
2040	8.52	3.25	-5.27
2045	8.78	3.26	-5.52
2050	8.97	3.27	-5.70
2055	9.18	3.28	-5.90
2060	9.47	3.30	-6.17
2065	9.80	3.31	-6.49
2069	10.11	3.32	-6.79

¹Under the intermediate assumptions.²See footnote 1 of table I.D1.³Difference between the income rates and cost rates. Negative values represent deficits.

While the year-by-year comparisons discussed are necessary to measure the adequacy of the financing of the HI program, the financial status of the program is often summarized, over a specific projection period, by a single measure known as the actuarial balance. The actuarial balance of the HI program is defined to be the difference between the summarized income rate for the valuation period and the summarized cost rate for the same period. The summarized income rates, cost rates, and actuarial balance are based upon the present values of future income on an incurred basis, future insured costs on an incurred basis, and future taxable payroll. The present values are calculated by discounting the future annual amounts of income and outgo at the assumed rates of interest credited to the HI trust fund. The present values are calculated as of the beginning of the valuation period. The summarized income and cost rates over the projection period are then obtained by dividing the present value of the taxable payroll into the present values of income and cost, respectively. The difference between the summarized income rate and cost rate over the long-range projection period, after an adjustment to take into account the fund balance at the valuation date and any target trust fund at the end of the valuation period, is computed to obtain the actuarial balance. In keeping with a decision by the Board of

Trustees that it is advisable to maintain a balance in the trust fund equal to a minimum of one year's expenditures, the target trust fund balance is equal to the following year's estimated costs at the end of the 75-year projection period. It should be noted that projecting an end-of-period target trust fund balance does not necessarily insure that the trust fund will maintain such a balance on a year-by-year basis.²

The actuarial balance can be interpreted as the immediate, level, and permanent percentage that must be added to the current law income rates and/or subtracted from the current law cost rates throughout the entire valuation period in order for the financing to support program costs and provide for the targeted trust fund balance at the end of the projection period. The income rate increase according to this method is 3.52 percent of taxable payroll. However, if income rates or cost rates were not changed until the year the trust fund falls below the 100-percent level recommended by the Board of Trustees, then the level of the increase would have to be 3.65 percent of taxable payroll under the intermediate assumptions. If no changes were made until the year the trust fund would be exhausted, then the required increase would be 3.91 percent of taxable payroll.

The actuarial balances under all three alternative sets of assumptions, for the next 25, 50, and 75 years, as well as for each 25-year subperiod, are shown in Table I.D3. The summarized income rate for the entire 75-year period under the intermediate assumptions is 3.16 percent of taxable payroll. The summarized cost of the program under the intermediate assumptions, for the entire 75-year period, is 6.69 percent, or more than twice the level of projected income to the program. As a result, the HI program fails to meet the Trustees' long-range test of close actuarial balance. (The Glossary to this report contains a summary of the requirements of this test.)

² An alternative way of calculating actuarial status, known as the modified average-cost method, is presented in section III.A. The HI trust fund also fails the test of long-range close actuarial balance using this method.

TABLE I.D3. -- ACTUARIAL BALANCES OF THE HI PROGRAM, UNDER THREE SETS OF ASSUMPTIONS

	Intermediate	Alternative	
	assumptions	Low Cost	High Cost
Projection periods:			
1995-2019:			
Summarized income rate	3.04%	3.03%	3.06%
Summarized cost rate ¹	4.37	3.51	5.53
Actuarial balance ²	-1.33	-0.48	-2.47
1995-2044:			
Summarized income rate	3.12	3.08	3.16
Summarized cost rate ¹	5.79	3.85	9.13
Actuarial balance ²	-2.68	-0.77	-5.98
1995-2069:			
Summarized income rate	3.16	3.11	3.22
Summarized cost rate ¹	6.69	4.14	11.27
Actuarial balance ²	-3.52	-1.03	-8.04
25-year subperiods:			
1995-2019:			
Summarized income rate	3.04%	3.03%	3.06%
Summarized cost rate ³	4.35	3.55	5.40
Actuarial balance ²	-1.30	-0.52	-2.34
2020-2044:			
Summarized income rate	3.21	3.15	3.27
Summarized cost rate ³	7.53	4.29	13.44
Actuarial balance ²	-4.32	-1.14	-10.17
2045-2069:			
Summarized income rate	3.29	3.18	3.43
Summarized cost rate ³	9.32	4.93	17.88
Actuarial balance ²	-6.03	-1.75	-14.45

¹Expenditures for benefit payments and administrative costs for insured beneficiaries, on an incurred basis, expressed as a percentage of taxable payroll, computed on the present-value basis, including the cost of attaining a trust fund balance at the end of the period equal to 100% of the following year's estimated expenditures, and including an offset to cost due to the beginning trust fund balance.

²Difference between the summarized income rate and the summarized cost rate.

³Expenditures for benefit payments and administrative costs for insured beneficiaries, on an incurred basis, expressed as a percentage of taxable payroll, computed on the present-value basis. Includes neither the trust fund balance at the beginning of the period nor the cost of attaining a non-zero trust fund balance at the end of the period.

The divergence in outcomes among the three alternatives is reflected both in the estimated operations of the trust fund on a cash basis (as discussed in section I.C) and in the 75-year summarized costs. The variations in the

underlying assumptions, as shown in the technical section, can be characterized as (1) moderate in terms of magnitude of the differences on a year-by-year basis and (2) persistent over the duration of the projection period. During the first 25-year projection period, under the intermediate assumptions, program expenditures are projected to increase faster than taxable payroll, at a rate which gradually declines to about 2 percent more per year than taxable payroll by 2010. However, program expenditures are expected to grow at a rate of about 3 percent more than taxable payroll for the intermediate estimate by 2019, the last year of the first 25-year projection period, as a result of demographic factors (as described below). Under the low cost alternative, program expenditures are also projected to increase faster than taxable payroll, but at a somewhat lower rate, which gradually declines to about 0.2 percent more per year than taxable payroll by 2010; the rate then increases, reaching about 1.3 percent more per year than taxable payroll by 2019. Similarly, the high cost alternative follows a pattern whereby program expenditures initially increase faster than taxable payroll and at a somewhat higher rate than under the intermediate assumptions, gradually declining to about 3.4 percent more than taxable payroll by 2010, and then increasing to about 5 percent more than taxable payroll by 2019.

Past experience has indicated that economic and demographic conditions as financially adverse as those assumed under the high cost alternative can, in fact, occur. None of the alternative projections should be viewed as unlikely or unrealistic. The wide range of results under the three alternatives is indicative of the uncertainty of the program's future cost, and its sensitivity to future economic and demographic conditions. Accordingly, it is important that an adequate balance be maintained in the HI trust fund as a reserve for contingencies, and that financial imbalances be addressed promptly through corrective legislation.

A valuation period of 75 years is needed to present fully the future contingencies that reasonably may be expected to occur, such as the impact of the large shift in the demographic composition of the population which will occur after the turn of the century. As Table I.D2 indicates, estimated expenditures under the program, expressed as percentages of taxable payroll, increase rapidly during the second 25 years of the projection period. This rapid increase in costs occurs because the relatively large number of persons born during the period between the end of World War II and the mid-1960's (known as the baby boom) will reach retirement age and begin to receive benefits, while the relatively smaller number of persons born during later years will comprise the labor force. During the last 25 years of the projection

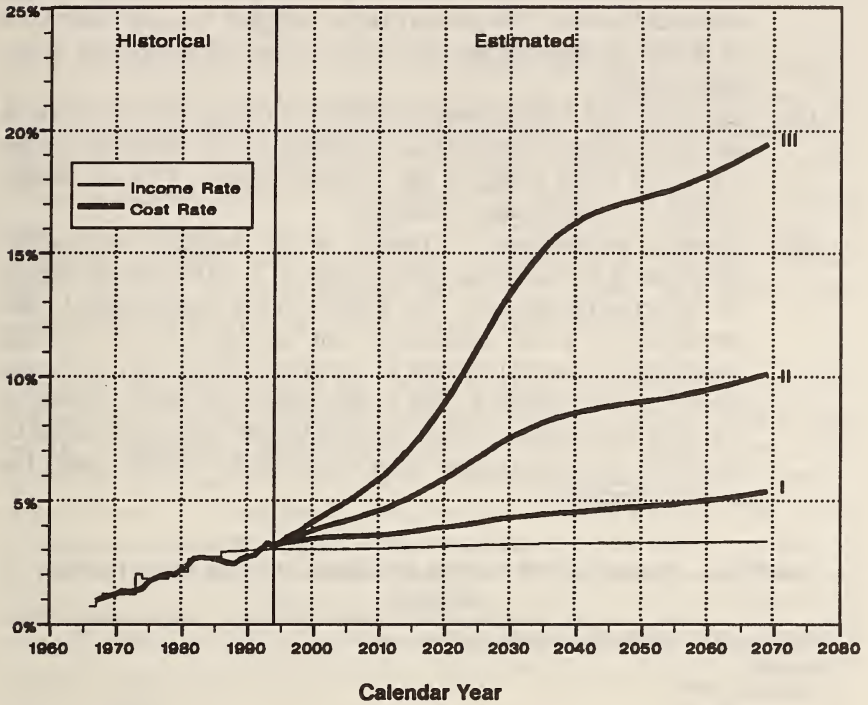
period, the projected increases in expenditures under the program stabilize somewhat.³

Costs beyond the initial 25-year projection period for the intermediate estimate are based upon the assumption that costs per unit of medical care service will increase at the same rate as that of average hourly earnings. Thus, changes in the last fifty years of the projection period primarily reflect the impact of the changing demographic composition of the population. Beyond the initial 25-year projection period, the low cost and high cost alternatives assume that program cost increases, relative to taxable payroll increases, are initially 2 percent less rapid and 2 percent more rapid, respectively, than the results under the intermediate assumptions. The initial 2-percent differentials are assumed to gradually decrease until the year 2044, when program cost increases (relative to taxable payroll) are assumed to be the same as under the intermediate assumptions.

Figure 3 shows the year-by-year costs as a percent of taxable payroll for each of the three sets of assumptions, as well as the projected income rates. The income rates are shown only for the intermediate assumptions in order to simplify the graphical presentation and because the variation in the income rates by alternative is very small. The long-range summarized income rates for the low cost and high cost alternatives, for the 75-year valuation period, differ by only 0.11 percent of taxable payroll. By 2069, the annual income rates under the low cost and high cost alternatives differ by only about 0.3 percent of taxable payroll. Only small fluctuations are projected in the income rate, as the rate of income from taxation of OASDI benefits varies only slightly for each alternative. Figure 3 illustrates the magnitude of the projected financial imbalance in the HI program by displaying the divergence of the program costs and income rates under each set of assumptions. In the figure, the labels "I," "II," and "III" indicate projections under the low cost, intermediate, and high cost alternatives, respectively.

³ HI costs as a percentage of taxable payroll are projected to continue to increase, at a slower rate, due to assumed further improvements in life expectancy.

Figure 3. ESTIMATED HI COSTS AND INCOME RATES AS PERCENT OF TAXABLE PAYROLL



The 75-year actuarial balance of the HI program, under the intermediate assumptions, is estimated to be -3.52 percent of taxable payroll, as shown in Table I.D3. The actuarial balance under the intermediate assumptions as reported in the 1994 Annual Report was -4.14 percent. The major reasons for the change in the 75-year actuarial balance are summarized in Table I.D4. In more detail, these changes are:

- (1) Changes in valuation period: Changing the valuation period from 1994-2068 to 1995-2069 adds a very large deficit year to the calculation of the actuarial balance. The effect on the actuarial balance is -0.10 percent of taxable payroll.
- (2) Updating the projection base: The cost as a percent of payroll for 1994 was less than estimated in the 1994 report. The net effect of this change on the actuarial balance is +0.16 percent.

- (3) Other provider assumptions: Changes to the non-hospital provider utilization assumptions result in a -0.09 percent change in the actuarial balance. The primary factor is higher assumed utilization of skilled nursing facilities in the short-range than assumed in last year's report.
- (4) Economic and demographic assumptions: Changes in the economic and demographic assumptions described in the technical section result in a +0.01 change in the actuarial balance. This was mostly the effect of short-range variations.
- (5) Hospital assumptions: Changes in the hospital assumptions described in the technical section result in a +0.64 percent change in the actuarial balance. The primary factor contributing to this improvement is an assumption that increases in the average complexity of hospital services in the future will be more moderate than previously assumed. This assumption change was prompted by the most recent actual experience with the mix of cases reported by hospitals; in particular, the trend toward more complex cases has slowed somewhat.

TABLE I.D4. – CHANGE IN THE 75-YEAR ACTUARIAL BALANCE SINCE THE 1994 REPORT

1. Actuarial balance, intermediate assumptions, 1994 report	-4.14%
2. Changes:	
a. Valuation period	-0.10
b. Base estimate	+0.16
c. Other provider assumptions	-0.09
d. Economic and demographic assumptions	+0.01
e. Hospital assumptions	+0.64
f. Net effect, above changes	+0.62
3. Actuarial balance, intermediate assumptions, 1995 report	-3.52

E. CONCLUSION

The balance in the Federal Hospital Insurance Trust Fund at the beginning of 1995 was 117 percent of estimated outgo for calendar year 1995, which exceeds the minimum 100 percent level recommended by the Board of Trustees by a small margin. However, the tax rates specified in the law are sufficient, along with interest earnings, other income, and assets in the fund, to support program expenditures only over the next 7 years, under the Trustees' intermediate assumptions. As a result, the trust fund does not meet the Trustees' short-range test of financial adequacy, which was described in

a previous section of this report. Under all three sets of assumptions, moreover, the HI trust fund is projected to become exhausted within the next 6 to 11 years.

Over the 75-year projection period, the income rate necessary to provide for benefits and administrative expenses substantially exceeds the income rate currently scheduled in the law for all future years. The actuarial balance (as defined in the previous section) is -1.33 percent of taxable payroll for the first 25-year projection period, -2.68 percent for the first 50-year projection period, and -3.52 percent over the entire 75-year projection period, under the intermediate assumptions. The actuarial balances for the 25-year subperiods are -1.30, -4.32, and -6.03 percent for the first, second, and third 25-year subperiods, respectively, under the intermediate assumptions.

The trust fund fails to meet the Trustees' test of long-range close actuarial balance (see Glossary) by an extremely wide margin. This test, which is based on the intermediate assumptions, would also be failed even under the favorable economic and demographic conditions assumed for the low cost assumptions. To bring the HI program into actuarial balance even for the first 25 years under the intermediate assumptions would require an increase in the HI payroll tax rate of about 0.65-percentage-point for employees and employers, each, or a comparable reduction in benefits (or some combination thereof). Equivalently, either outlays would have to be reduced by 30 percent or income increased by 44 percent (or some combination thereof) throughout this 25-year period.

Currently about four covered workers support each HI enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of that century, only about two covered workers will support each enrollee. As the post-World War II baby boom generation becomes eligible for benefits, the annual percentage increase in program costs as a percentage of taxable payroll will accelerate significantly, from about 2 percent per year in 2010 to 3 percent in 2019 under the intermediate assumptions. Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, but under all the sets of assumptions the HI trust fund is projected to become exhausted before the demographic shift has even begun to occur. Exhaustion is projected to occur around the turn of the century, in 2002 under the intermediate assumptions and in 2001 if the high cost assumptions are realized.

Overview

The Trustees note that some steps have been taken to reduce the rate of growth in payments to hospitals, including the implementation of the prospective payment system for most hospitals. Experience to date suggests that this reimbursement mechanism, together with payment limitation provisions enacted by the Congress, has helped to constrain the growth in hospital payments and has improved the efficiency of the hospital industry. Extension of this payment system to other providers of HI services and further legislation to limit payment increases to all HI providers could postpone the depletion of the HI trust fund for about another 5 to 10 years. Much more substantial steps would be required, however, to prevent trust fund depletion beyond 2010 when the baby boom generation begins to reach age 65.

Under present law, as shown by the projections in this report, HI program costs are expected to far exceed revenues over the 75-year long-range period under any reasonable set of assumptions. As a result, the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program.

Even though the long-range status of the HI program has improved somewhat since last year's report, it remains extremely unfavorable. In addition, the HI trust fund continues to fail the short-range test of financial adequacy and is projected to experience increasing annual deficits in future years, beginning in calendar year 1996. In view of these results, the Board of Trustees is again alerting the Congress to the significant financial imbalance in the HI trust fund.

The cost of the HI program is projected to increase from 1.6 percent of gross domestic product in calendar year 1994 to 4.4 percent of GDP in 2065. This rapid growth is attributable primarily to anticipated increases in hospital admissions and service complexity, together with expected changes in demographics. With the magnitude of the projected actuarial deficit in the HI program and the high probability that the HI trust fund will be exhausted in less than 11 years, the Trustees urge the Congress to take additional actions designed to control HI program costs and to address the projected financial imbalance in both the short-range and the long-range through specific program legislation as part of broad-based health care reform. The Trustees believe that prompt, effective, and decisive action is necessary.

To facilitate this effort, the Trustees further recommend legislation to reestablish the Quadrennial Advisory Council for the Medicare program. This

Conclusion

action would help provide critical information that will be needed by the Administration and the Congress as they deliberate the future of the HI program and would help ensure that such information will be available in time to assist the orderly development of legislative solutions. The Trustees believe that prompt action on reestablishing the Advisory Council will help to expedite the legislative process and lead to effective solutions to the short-range and long-range financial problems of the HI program.

II. TECHNICAL SECTION

A. SOCIAL SECURITY AMENDMENTS SINCE THE 1994 REPORT

Since the 1994 Annual Report was transmitted to Congress on April 11, 1994, there have been no legislative changes enacted which would have a significant effect on the financial status of the HI program.

However, the Social Security Independence and Program Improvements Act of 1994 (Public Law 103-296, signed on August 15, 1994) established the Social Security Administration as an independent agency, effective March 31, 1995. Under the new law, the Commissioner of Social Security is appointed by the President and confirmed by the Senate to serve a 6-year term. The law provides that the Commissioner of Social Security is a member of the Board of Trustees for the Federal Hospital Insurance Trust Fund.

B. NATURE OF THE TRUST FUND

The Federal Hospital Insurance Trust Fund was established on July 30, 1965, as a separate account in the United States Treasury. All the financial operations of the HI program are handled through this fund.

The primary source of income to the trust fund is amounts appropriated to it under permanent authority on the basis of contributions paid by workers, their employers, and individuals with self-employment income, in work covered by the HI program. Beginning January 1, 1987, these appropriated amounts include contributions paid by, or on behalf of, workers employed by State and local governments and their employers, with respect to work covered by the program through State agreements. (Prior to 1987, such contributions were deposited directly into the trust fund.) The coverage of the HI program includes workers covered under the old-age, survivors, and disability insurance (OASDI) program, those covered under the railroad retirement program, and certain Federal, State, and local employees not otherwise covered under the OASDI program.

All employees and their employers in employment covered by the program are required to pay contributions on the wages of individual workers, including cash tips. All covered self-employed persons are required to pay contributions on their self-employment income.

Technical Section

In general, for calendar years prior to 1994, an individual's contributions were computed on annual wages or self-employment income, or both wages and self-employment income combined, up to a specified maximum annual amount, with the contributions being determined first on the wages and then on any self-employment income up to the maximum annual amount. An employee who paid contributions on wages in excess of the annual maximum amount (because of employment with two or more employers) was eligible for a refund of the excess employee contributions. The amount of contributions subject to refund for any period was a charge against the trust fund. The maximum amount of earnings on which contributions were payable in a year is called the maximum contribution base. The maximum contribution base has been eliminated effective January 1, 1994; consequently, HI taxes are now payable on a covered individual's total wages and self-employment income, without limit.

The HI contribution rates applicable to taxable earnings in each of the calendar years 1966 and later are shown in Table II.B1. For 1996 and later, the contribution rates shown are the rates scheduled in the provisions of present law. The contribution bases are also shown. For 1975 to 1978, the contribution bases were determined under the automatic-adjustment provisions in section 230 of the Social Security Act. The bases for 1979 to 1981 were specified in the law, as amended in 1977. For 1982 to 1990 and for 1992 and 1993, the automatic-adjustment provisions were again applicable. For calendar year 1991, the contribution base was specified in the law as amended in 1990. The Omnibus Budget Reconciliation Act of 1993 eliminated the HI contribution bases for calendar years 1994 and later; therefore, for those years, all earnings in covered employment are subject to the contribution rate.

TABLE II.B1. -- CONTRIBUTION RATES AND MAXIMUM TAXABLE AMOUNT OF ANNUAL EARNINGS

Calendar years	Maximum taxable amount of annual earnings	Contribution rate (Percent of taxable earnings)	
		Employees and employers, each	Self- employed
Past experience:			
1966	\$6,600	0.35	0.35
1967	6,600	0.50	0.50
1968-71	7,800	0.60	0.60
1972	9,000	0.60	0.60
1973	10,800	1.00	1.00
1974	13,200	0.90	0.90
1975	14,100	0.90	0.90
1976	15,300	0.90	0.90
1977	16,500	0.90	0.90
1978	17,700	1.00	1.00
1979	22,900	1.05	1.05
1980	25,900	1.05	1.05
1981	29,700	1.30	1.30
1982	32,400	1.30	1.30
1983	35,700	1.30	1.30
1984	37,800	1.30	2.60
1985	39,600	1.35	2.70
1986	42,000	1.45	2.90
1987	43,800	1.45	2.90
1988	45,000	1.45	2.90
1989	48,000	1.45	2.90
1990	51,300	1.45	2.90
1991	125,000	1.45	2.90
1992	130,200	1.45	2.90
1993	135,000	1.45	2.90
1994-95	no limit	1.45	2.90
Scheduled in present law:			
1996 & later	no limit	1.45	2.90

All contributions are collected by the Internal Revenue Service and deposited in the general fund of the Treasury as internal revenue collections. The contributions received are automatically appropriated, on an estimated basis, to the trust fund. The exact amount of contributions received is not known initially since HI contributions, OASDI contributions, and individual income taxes are not separately identified in collection reports received by the Treasury Department. Periodic adjustments are subsequently made to the extent that the estimates are found to differ from the amounts of contributions actually payable on the basis of reported earnings.

Technical Section

Prior to May 1983 and after June 1984, the estimated internal revenue collections were transferred to the trust funds immediately upon receipt. For May 1983 through June 1984, estimated total collections for each month were credited to the trust funds on the first day of the month. As the actual collections were received during the month, they were deposited in the general fund of the Treasury and remained there. The trust funds paid interest to the general fund to reimburse it for the interest lost because of this provision.

Since 1984, up to one-half of an individual's or couple's OASDI benefits has been subject to Federal income taxation under certain circumstances, and the proceeds from this taxation have been allocated to the OASI and DI trust funds. Beginning in 1994, the maximum percentage of OASDI benefits so taxed is increased under certain circumstances, from 50 percent to 85 percent, and the revenue attributable to this increased portion of benefits subject to taxation is allocated to the HI trust fund.

Another substantial source of trust fund income is interest credited from investments in government securities held by the fund. The investment procedures of the fund are described later in this section.

The income and expenditures of the trust fund are also affected by the provisions of the Railroad Retirement Act which provide for a system of coordination and financial interchange between the railroad retirement program and the HI program.

Sections 217(g) and 229(b) of the Social Security Act, prior to modification by the Social Security Amendments of 1983, authorized annual reimbursement from the general fund of the Treasury to the HI trust fund for costs arising from the granting of deemed wage credits for military service prior to 1957, according to quinquennial determinations made by the Secretary of Health and Human Services. These sections, as modified by the Social Security Amendments of 1983, provided for a lump sum transfer in 1983 for costs arising from such wage credits. In addition, the lump sum transfer included combined employer-employee HI taxes on the noncontributory wage credits for military service after 1965 and before 1984. After 1983, HI taxes on military wage credits are credited to the fund on July 1 of each year. The Social Security Amendments of 1983 also provided for (1) quinquennial adjustments to the lump sum amount transferred in 1983 for costs arising from pre-1957 deemed wage credits and (2) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on noncontributory wage credits.

Section 231 of the Social Security Act authorizes reimbursement from the general fund of the Treasury to the HI trust fund for any costs arising from the granting of deemed wage credits to individuals who were interned during World War II at a place within the United States operated by the Federal Government for the internment of persons of Japanese ancestry.

Two sections of the statute authorize HI benefits for uninsured persons aged 65 and over. Section 103 of the Social Security Amendments of 1965 provided transitional entitlement to HI benefits to those who were 65 before 1968 or who attained age 65 after 1967 and had at least three quarters of covered employment. This entitlement does not apply for those who reach 65 after 1973. Section 278 of the Tax Equity and Fiscal Responsibility Act of 1982 added similar transitional entitlement for those federal employees who would retire before having a chance to earn sufficient quarters of Medicare-qualified federal employment. This provision allows those who were employed by the Federal Government during and before January, 1983, to have the necessary quarters of federal employment counted toward their Medicare entitlement. Such payments are made initially from the HI trust fund, with reimbursement from the general fund of the Treasury for the costs, including administrative expenses, of the payments. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.

Section 1818 of the Social Security Act provides that certain persons not eligible for HI protection either on an insured basis or on the uninsured basis described in the previous paragraph may obtain protection by enrolling in the program and paying a monthly premium.

Section 201(i) of the Social Security Act authorizes the Managing Trustee to accept and deposit in the trust fund unconditional money gifts or bequests made for the benefit of the fund or any activity financed through the fund.

Expenditures for benefit payments and administrative expenses under the HI program are paid from the trust fund. All expenses incurred by the Department of Health and Human Services, The Social Security Administration, and the Treasury Department in carrying out the provisions of title XVIII of the Social Security Act pertaining to the HI program and of the Internal Revenue Code relating to the collection of contributions are charged to the trust fund. The Secretary of Health and Human Services

Technical Section

certifies benefit payments to the Managing Trustee, who makes the payments from the trust fund in accordance therewith.

Prior to fiscal year 1984, hospitals, at their option, were permitted to combine their billing for both hospital and physician components of radiology and pathology services rendered to hospital inpatients by hospital-based physicians. Where hospitals elected this billing procedure, payments were made initially from the HI trust fund. The reimbursements so made were on a provisional basis and are subject to adjustment, with appropriate interest allowance.

The Social Security Amendments of 1967 and 1972 authorize the Secretary of Health and Human Services to develop and conduct a broad range of experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under the HI and supplementary medical insurance (SMI) programs. A sizable portion of the costs of such experiments and demonstration projects is paid from the HI and SMI trust funds.

Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of the HI program. Both the capital costs of construction financed directly through the trust funds and the rental and lease, or purchase contract costs of acquiring facilities are included in trust fund expenditures. In 1972-75, construction of several large facilities was authorized under purchase contract authority, wherein initial capital costs were borne by the private sector. Under this method of facilities acquisition, trust fund expenditures for use and ultimate Government ownership of a facility are made over periods of from 10 to 30 years. Whatever the manner of acquisition, the net worth of facilities and other fixed capital assets is not carried in the statement of the assets of the trust fund presented in this report. This is because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and, therefore, is not viewed as being a consideration in assessing the actuarial status of the funds.

That portion of the trust fund which, in the judgment of the Managing Trustee, is not required to meet current expenditures for benefits and administration, is invested, on a daily basis, primarily in interest-bearing obligations of the U.S. Government (including special public-debt obligations described below). Investment may also be made in obligations guaranteed as to both principal and interest by the United States, including certain federally

sponsored agency obligations that are designated in the laws authorizing their issuance as lawful investments for trust funds under the control and authority of the United States or any officer of the United States. These obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price.

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall bear interest at a rate based on the average market yield (computed on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such month. These special issue securities are redeemable at par value at all times, and so are not subject to the uncertainty of price fluctuations as interest rates change.

From December 29, 1981, until January 1, 1988, the Social Security Act authorized borrowing among the OASI, DI, and HI trust funds when necessary "to best meet the need for financing the benefit payments" from the three funds. Interfund loans under the borrowing authority were made to the OASI trust fund from the DI and HI trust funds in 1982, and were fully repaid by May 1986. In this report, the assets of the HI trust fund at the end of 1982 through 1985, inclusive, do not include the amounts owed to the trust fund. This procedure is followed because the borrowed amounts were available to the borrowing fund for the payment of benefits or other obligations, while such amounts were not readily available to the lending fund.

Technical Section

C. SUMMARY OF THE OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1994

A statement of the revenue and disbursements of the Federal Hospital Insurance Trust Fund in fiscal year 1994, and of the assets of the fund at the beginning and end of the fiscal year, is presented in Table II.C1.

The total assets of the trust fund amounted to \$126,131 million on September 30, 1993. During fiscal year 1994, total revenue amounted to \$106,195 million, and total disbursements were \$102,770 million. The assets of the trust fund thus increased by \$3,425 million during the year to a total of \$129,555 million on September 30, 1994.

TABLE II.C1. -- STATEMENT OF OPERATIONS OF THE HI TRUST FUND DURING FISCAL YEAR 1994
(In thousands of dollars)

Total assets of the trust fund, beginning of period	\$126,130,598
Revenue:	
Appropriation of employment taxes	\$92,100,426
Refunds of employment taxes	-72,500
Deposits arising from State agreements	-82
Income from taxation of OASDI benefits	1,639,000
Interest on investments	10,571,885
Premiums collected from voluntary participants	852,249
Transfer from railroad retirement account	378,400
Transitional uninsured coverage	506,000
Military service credits of 1994	80,448
Reimbursement, program management general fund	100,962
Interest on reimbursements, SSA ¹	131
Interest on reimbursements, HCFA ¹	2,204
Interest on reimbursements, Railroad Retirement	34,531
Other	1,238
Total revenue	<u>\$106,194,890</u>
Disbursements:	
Benefit payments	\$101,535,341
Administrative expenses:	
Treasury administrative expenses	32,305
Salaries and expenses, SSA ²	432,440
Salaries and expenses, HCFA ³	744,393
Salaries and expenses, Office of Secretary	18,417

**TABLE II.C1. -- STATEMENT OF OPERATIONS OF THE HI TRUST FUND DURING
FISCAL YEAR 1994**
(In thousands of dollars)

Construction expenses, SSA	260
Payment Assessment Committee	3,570
Policy and Research	3,472
Total disbursements	\$102,770,198
Total assets of the trust fund, end of period	\$129,555,290

¹ A positive figure represents a transfer to the HI trust fund from the other trust funds. A negative figure represents a transfer from the HI trust fund to the other trust funds.

² For facilities, goods, and services provided by the Social Security Administration (SSA).

³ Includes administrative expenses of the intermediaries.

NOTE: Totals do not necessarily equal the sums of rounded components.

Included in total revenue during fiscal year 1994 was \$92,100 million representing contributions appropriated to the trust fund. As an offset, \$72 million was transferred from the trust fund into the Treasury as repayment for the estimated amount of contributions subject to refund to employees who worked for more than one employer during the course of a year and paid contributions on wages in excess of the statutory maximum earnings base, and \$0.1 million was transferred from the trust fund to State and local governments for overpayments from previous State agreements for coverage of State and local government employees.

Net contributions amounted to \$92,028 million, representing an increase of 10.7 percent over the amount of \$83,147 million for the preceding 12-month period. This growth in contribution income resulted primarily from (1) the higher level of earnings in covered employment and (2) the two increases in the maximum annual amount of earnings taxable from \$130,200 to \$135,000 and from \$135,000 to no limit that became effective January 1, 1993, and January 1, 1994, respectively.

Income from the taxation of OASDI benefits, as described in Section II.B, amounted to \$1,639 million in fiscal year 1994.

Section II.B referred to provisions under which the HI trust fund is to be reimbursed from the general fund of the Treasury for costs of paying benefits under this program on behalf of certain uninsured persons. The reimbursement in fiscal year 1994 amounted to \$506 million (\$458 million for

Technical Section

the non-federal uninsured and \$48 million for the federal uninsured), consisting of \$501 million for benefit payments and \$5 million for administrative expenses.

Section II.B referred to provisions of the Social Security Act under which certain persons not otherwise eligible for HI protection may obtain such protection by enrolling in the program and paying a monthly premium. Premiums collected from such voluntary participants in fiscal year 1994 amounted to about \$852 million.

In accordance with the provisions of the Railroad Retirement Act which coordinate the railroad retirement and the HI programs and which govern the financial interchange arising from the allocation of costs between the two systems, the Railroad Retirement Board and the Secretary of Health and Human Services determined that a transfer of about \$378 million in principal and \$16 million in interest from the railroad retirement program's Social Security Equivalent Benefit Account to the HI trust fund would place this fund in the same position, as of September 30, 1993, in which it would have been if railroad employment had always been covered under the Social Security Act. This amount, together with interest to the date of transfer amounting to about \$19 million, was transferred to the trust fund in June 1994.

In accordance with provisions for the appropriation to the trust fund of HI taxes on noncontributory military wage credits as discussed in section II.B, the trust fund was credited on July 1, 1994 with \$80 million for calendar year 1994 taxes on wage credits.

The remaining \$10,676 million of revenue consisted almost entirely of interest credited from the investments held by the trust fund.

Of the \$102,770 million in total disbursements, \$101,535 million represented benefits paid directly from the trust fund for health services covered under title XVIII of the Social Security Act. Benefit payments increased 11.9 percent in fiscal year 1994 over the corresponding amount of \$90,738 million paid during the preceding 12 months.

The remaining \$1,235 million of disbursements was for net administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds--OASI, DI, HI, and SMI--on the basis of provisional estimates. Similarly, the expenses of administering other programs of the

Health Care Financing Administration are also allocated and charged directly to the general fund of the Treasury on a provisional basis. Periodically, as actual experience develops and is analyzed, adjustments to the allocations of administrative expenses and costs of construction for prior periods are effected by interfund transfers, including transfers between the HI and SMI trust funds and the program management general fund account, with appropriate interest allowances.

Table II.C2 compares the actual experience in fiscal year 1994 with the estimates presented in the 1993 and 1994 annual reports. Section II.B referred to the appropriation of contributions to the trust funds on an estimated basis, with subsequent periodic adjustments to account for differences from the amounts of contributions actually payable on the basis of reported earnings. In interpreting the figures in Table II.C2, it should be noted that the "actual" amount of contributions in fiscal year 1994 reflects the aforementioned type of adjustments to contributions for prior fiscal years. On the other hand, the "actual" amount of contributions for fiscal year 1994 does not reflect adjustments to contributions for fiscal year 1994 that were to be made after September 30, 1994.

TABLE II.C2. -- COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE HI TRUST FUND, FISCAL YEAR 1994
(Dollar amounts in millions)

Item	Comparison of actual experience with estimates for fiscal year 1994 published in--				
	Actual amount	1994 report		1993 report	
		Estimated amount ¹	Actual as percentage of estimate	Estimated amount ¹	Actual as percentage of estimate
Net contributions	\$92,028	\$90,734	101	\$89,921	102
Benefit payments	\$101,535	\$103,212	98	\$101,571	100

¹Under the intermediate assumptions (which were called "Alternative II" in the 1993 report).

The assets of the HI trust fund at the end of fiscal year 1993 totaled \$126,131 million, consisting of \$126,078 million in the form of obligations of the U.S. Government and an undisbursed balance of \$52 million. The assets of the HI trust fund at the end of fiscal year 1994 totaled \$129,555 million, consisting of \$128,716 million in the form of U.S. Government obligations and an undisbursed balance of \$840 million. Table II.C3 shows the total assets of the fund and their distribution at the end of fiscal years 1993 and 1994.

Technical Section

TABLE II.C3. -- ASSETS OF THE HI TRUST FUND, BY TYPE, AT THE END OF FISCAL YEARS 1993 AND 1994¹

	September 30, 1993	September 30, 1994
Investments in public-debt obligations sold only to the trust funds (special issues):		
Certificates of indebtedness:		
5 5/8-percent, 1994	\$1,160,387,000.00	-----
7 1/4-percent, 1995	-----	\$868,196,000.00
Bonds:		
6 1/4-percent, 1995	363,197,000.00	-----
6 1/4-percent, 1996-2008	12,906,496,000.00	12,906,496,000.00
7 1/4-percent, 1996-2009	-----	11,699,938,000.00
7 3/8-percent, 1995	867,961,000.00	-----
7 3/8-percent, 1996-2007	17,732,498,000.00	17,732,498,000.00
8 1/8-percent, 1995	901,273,000.00	-----
8 1/8-percent, 1996-2006	16,329,702,000.00	16,329,702,000.00
8 3/8-percent, 1995	1,059,024,000.00	-----
8 3/8-percent, 1996-2001	8,321,957,000.00	8,321,957,000.00
8 5/8-percent, 1995	573,791,000.00	-----
8 5/8-percent, 1995-2002	7,999,154,000.00	7,664,228,000.00
8 3/4-percent, 1994	3,034,212,000.00	-----
8 3/4-percent, 1995-2005	32,503,153,000.00	32,503,153,000.00
9 1/4-percent, 1994	1,034,541,000.00	-----
9 1/4-percent, 1995-2003	12,506,276,000.00	12,506,276,000.00
9 3/4-percent, 1994	130,210,000.00	-----
9 3/4-percent, 1995	979,670,000.00	979,670,000.00
10 3/8-percent, 1998-2000	2,131,610,000.00	2,131,610,000.00
10 3/4-percent, 1998	588,410,000.00	588,410,000.00
13 -percent, 1994	197,606,000.00	-----
13 -percent, 1995-1996	1,374,882,000.00	1,374,882,000.00
13 1/4-percent, 1994	272,853,000.00	-----
13 1/4-percent, 1995-1997	1,995,835,000.00	1,995,835,000.00
13 3/4-percent, 1998-1999	1,112,678,000.00	1,112,678,000.00
Total investments	\$126,078,376,000.00	\$128,715,529,000.00
Undisbursed balance ²	52,221,829.52	839,761,323.57
Total assets	\$126,130,597,829.52	\$129,555,290,323.57

¹Certificates of indebtedness and bonds are carried at par value, which is the same as book value.

²The unusually large undisbursed balance as of September 30, 1994, was due to the receipt of employment taxes on that day which were not subsequently invested until the next business day.

New securities at a total par value of \$112,269 million were acquired during the fiscal year through the investment of revenue and the reinvestment of funds made available from the redemption of securities. The par value of securities redeemed during the fiscal year was \$109,632 million. Thus, the net

increase in the par value of the investments held by the fund during fiscal year 1994 amounted to \$2,637 million.

The effective annual rate of interest earned by the assets of the HI trust fund during the 12 months ending on June 30, 1994, was 8.72 percent. (This period is used because interest on special issues is paid semiannually on June 30 and December 31.) The interest rate on public-debt obligations issued for purchase by the trust fund in June 1994 was 7.25 percent, payable semiannually.

D. ACTUARIAL METHODOLOGY AND PRINCIPAL ASSUMPTIONS FOR THE HOSPITAL INSURANCE COST ESTIMATES

This section describes the basic methodology and assumptions used in the estimates for the HI program under the intermediate assumptions. In addition, sensitivity testing of program costs under two alternative sets of assumptions is presented.

1. Assumptions

Both the economic and demographic assumptions underlying the projections shown in this report are consistent with those in the 1995 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance (OASDI) Trust Funds. These assumptions are described in more detail in that report.

2. Program Cost Projection Methodology

The principal steps involved in projecting the future costs of the HI program are (1) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base; (2) projecting increases in payments for inpatient hospital services under the program; (3) projecting increases in payments for SNF, HHA, and hospice services covered under the program; and (4) projecting increases in administrative costs. The major emphasis is directed toward expenditures for inpatient hospital services, which account for approximately 80 percent of total benefits.

Technical Section

a. Projection Base

In order to establish a suitable base from which to project the future costs of the program, the incurred payments for services provided must be reconstructed for the most recent period for which a reliable determination can be made. To do this, payments to providers must be attributed to dates of service, rather than to payment dates. In addition, the nonrecurring effects of any changes in regulations, legislation, or administration of the program and of any items affecting only the timing and flow of payments to providers must be eliminated. As a result, the rates of increase in the incurred cost of the program differ from the increases in cash disbursement shown in Tables I.C1 and I.C2.

For those expenses still reimbursed on a reasonable cost basis, the costs for covered services are determined on the basis of provider cost reports. Payments to a provider initially are made on an interim basis; to adjust interim payments to the level of retroactively determined costs, a series of payments or recoveries is effected through the course of cost settlement with the provider. The net amounts paid to date to providers in the form of cost settlements are known; however, the incomplete data available do not permit a precise determination of the exact amounts incurred during a specific period of time. Due to the time required to obtain cost reports from providers, to verify these reports, and to perform audits (where appropriate), final settlements have lagged behind the liability for such payments of recoveries by as much as several years for some providers. Hence, the final cost of services reimbursed on a reasonable cost basis has not been completely determined for the most recent years of the program, and some degree of uncertainty remains even for earlier years.

Even for inpatient hospital operating payments paid for on the basis of diagnosis-related groups (DRGs), most payments are initially made on an interim basis, and final payments are determined on the basis of bills containing detailed diagnostic information which are later submitted by the hospital.

Additional problems are posed by changes in legislation or regulation, or in administrative or reimbursement policy, which have a substantial effect on either the amount or incidence of payment. The extent and timing of the incorporation of such changes into interim payment rates and cost settlement amounts cannot be determined precisely.

The process of allocating the various types of payments made under the program to the proper incurred period--using incomplete data and estimates of the impact of administrative actions--presents difficult problems, the solutions to which can be only approximate. Under the circumstances, the best that can be expected is that the actual incurred cost of the program for a recent period can be estimated within a few percent. This increases the projection error directly, by incorporating any error in estimating the base year into all future years.

b. Payments for Inpatient Hospital Costs

Beginning with hospital accounting years starting on or after October 1, 1983, the HI program began paying almost all participating hospitals a prospectively-determined amount for providing covered services to beneficiaries. With the exception of certain expenses reimbursed on a reasonable cost basis, as defined by law, the payment rate for each admission depends upon the DRG to which the admission belongs.

The law contemplates that the annual increase in the payment rate for each admission will be related to a hospital input price index, which measures the increase in prices for goods and services purchased by hospitals for use in providing care to hospital inpatients. In other literature, the hospital input price index is also called the hospital market basket percentage increase. For fiscal years through 1995, the prospective payment rates have already been determined. The projections contained in this report are based on the assumption that for fiscal years 1996 and 1997, the prospective payment rates will be increased in accordance with Public Law 103-66, the Omnibus Budget Reconciliation Act of 1993, and these legislated annual payment rate increases are indeed functions of the annual hospital input price indices. For fiscal years 1998 and later, current statute mandates that the annual increase in the payment rate per admission equal the annual increase in the hospital input price index.

Increases in aggregate payments for inpatient hospital care covered under the HI program can be analyzed into four broad categories:

- (1) Labor factors--the increase in the hospital input price index which is attributable to increases in hospital workers' hourly earnings;

Technical Section

- (2) Non-labor factors--the increase in the hospital input price index which is attributable to factors other than hospital workers' hourly earnings, such as the costs of energy, food, and supplies;
- (3) Unit input intensity allowance--the increase in inpatient hospital payments per admission which are in excess of those attributable to increases in the hospital input price index; and
- (4) Volume of services--the increase in total output of units of service (as measured by hospital admissions covered by the HI program).

It has been possible to isolate some of these elements and to identify their roles in previous hospital payment increases. Table II.D1 shows the estimated values of the principal components of the increases for historical periods for which data are available and the projected trends used in the estimates. The following discussions apply to projections under the intermediate assumptions, unless otherwise indicated.

TABLE IL.D1.--COMPONENTS OF HISTORICAL AND PROJECTED INCREASES IN HI INPATIENT HOSPITAL PAYMENTS¹
(Percent)

Calendar year	Labor			Non-labor			Input price Index	Unit input intensity allowance ²	Units of service			HI Inpatient hospital payments
	Average hourly earnings	Hospital earnings differential	Hospital hourly earnings	CPI	Hospital price intensity	Non-labor hospital prices			HI enrollment	Admission incidence	Other Sources	
Historical Data:												
1984	6.4%	-0.7%	5.7%	3.5%	0.1%	3.6%	4.9%	1.0%	1.8%	-3.8%	8.0%	12.0%
1985	5.4	-0.8	4.6	3.5	-1.0	2.5	3.8	0.0	1.6	-7.4	8.6	6.1
1986	5.3	-1.6	3.6	1.6	-0.6	1.0	2.6	-2.5	2.3	-5.6	7.4	3.8
1987	4.7	-0.8	3.9	3.6	-0.4	3.2	3.7	-2.6	1.7	-3.1	1.6	1.2
1988	4.6	0.2	4.8	4.0	1.3	5.4	5.0	-2.5	2.5	-2.2	5.0	7.9
1989	3.3	1.8	5.2	4.8	0.8	5.6	5.4	-1.4	2.0	-3.2	6.2	9.1
1990	5.3	0.2	5.5	5.2	-1.2	3.9	4.9	-0.1	2.1	-0.3	1.1	7.9
1991	4.3	0.4	4.7	4.0	-1.7	2.2	3.7	-0.5	2.2	0.0	4.0	9.7
1992	5.8	-1.8	3.9	2.9	-1.2	1.7	3.1	-0.2	2.1	0.6	2.9	8.8
1993	2.9	0.6	3.5	2.8	-0.9	1.9	2.9	-0.3	2.1	0.3	2.8	8.0
Projection: ³												
1994	3.3	-0.2	3.1	2.5	-0.7	1.8	2.6	-0.9	2.1	1.3	2.1	7.4
1995	3.9	-0.5	3.4	3.1	0.9	4.0	3.6	-1.8	1.5	1.5	1.8	6.8
2000	4.3	0.4	4.7	3.7	0.0	3.7	4.4	0.0	1.3	1.1	1.3	8.3
2005	5.2	0.4	5.6	4.0	0.0	4.0	5.1	0.0	1.4	0.5	0.8	5.1
2010	5.2	0.4	5.6	4.0	0.0	4.0	5.1	0.0	1.8	0.1	0.7	7.8
2015	5.2	0.4	5.6	4.0	0.0	4.0	5.1	0.0	2.6	-0.1	0.7	8.5
2019	5.2	0.4	5.6	4.0	0.0	4.0	5.1	0.0	2.7	-0.2	0.7	8.5

¹Percent increase in year indicated over previous year, on an incurred basis.

²Reflects the allowances provided for in the prospective payment update factors.

³Under the intermediate assumptions.

Note: Historical and projected data reflect the hospital input price index which was recalibrated to a 1987 base year in 1990.

Technical Section

Increases in hospital workers' hourly earnings can be analyzed and projected in terms of the assumed increases in hourly earnings in employment in the general economy and the difference between hourly earnings increases in the general economy and the proxy for hospital hourly earnings used in the hospital input price index. Since the beginning of the HI program, the differential between the proxy for hospital workers' hourly earnings and hourly earnings in the general economy has fluctuated widely. Since 1984, this differential has averaged about -0.2 percent. During the initial years of the prospective payment system, it appears that hospital hourly earnings were depressed relative to those in the general economy as hospitals adapted to the prospective payment system. This differential is assumed to fluctuate, leveling off at 0.4 percent over the short term, declining to zero just after the end of the first 25-year projection period.

Increases in hospital price input intensity, which are primarily the result of price increases for non-labor goods and services that hospitals purchase which do not parallel increases in the Consumer Price Index (CPI), are measured as the difference between the non-labor component of the hospital input price index and the CPI. Although the level has fluctuated erratically in the past, this differential has averaged about -0.5 percent during 1984-1993. Over the short term, hospital price input intensity is assumed to fluctuate, leveling off to zero for most of the projection period.

For years prior to the beginning of the prospective payment system, the unit input intensity allowance has been set at 1 percent for illustrative purposes, with historical increases in excess of 1 percent allocated to other sources. For years after the beginning of the prospective payment system, the unit input intensity allowance is the allowance provided for in the prospective payment update factor; that is, the unit input intensity allowance is the amount added onto (or subtracted from) the input price index to yield the update factor. (It should be noted that the update factors are generally prescribed on a fiscal year basis, while Table II.D1 is on a calendar year basis. Calculations have therefore been performed to estimate the unit input intensity allowance on a calendar year basis.) For fiscal years 1994-1997, the allowances shown are prescribed in Public Law 103-66. (Again, calculations were performed to show the unit input intensity allowance on a calendar year basis.) Beginning in fiscal year 1998, the law provides that future increases in payments to participating hospitals for covered admissions will equal the increase in the hospital input price index. Thus, the unit input intensity allowance, as indicated in Table II.D1, is assumed to equal zero for the rest of the years in the first 25-year projection period.

Since the beginning of the prospective payment system, increases in inpatient hospital payments from other sources are primarily due to three factors: (1) the improvement in DRG coding as hospitals continue to adjust to the prospective payment system; (2) the trend toward treating less complicated (and thus, less expensive) cases in outpatient settings, resulting in an increase in the average prospective payment per admission; and (3) legislation affecting the payment rates. The effects of several budget reconciliation acts, sequesters as required by the Gramm-Rudman-Hollings Act, and other legislative effects are reflected in other sources, as appropriate. Some of the expansions in hospital payments due to the Medicare Catastrophic Coverage Act of 1988, and the subsequent reductions in hospital payments due to the Medicare Catastrophic Coverage Repeal Act of 1989, are reflected in other sources for 1989 to 1991. The assumed increase in this factor for fiscal years 1995 through 2019, which is 0.85 percent per year, is attributable to a continuation of the current trend toward treating less complicated cases in outpatient settings and continued improvement in DRG coding. Additionally, part of the increase from other sources can be attributed to the increase in payments for certain costs not included in the DRG payment; these costs are generally increasing at a rate faster than the input price index. Other possible sources of both relative increases and decreases in payments include (1) a shift to more or less expensive admissions (DRGs) due to changes in the demographic characteristics of the covered population; (2) changes in medical practice patterns; and (3) adjustments in the relative payment levels for various DRGs or addition/deletion of DRGs in response to changes in technology. As experience under the prospective payment system continues to develop and is further analyzed, it may be possible to establish a predictable trend for this component.

Other factors which contribute to increases in payments for inpatient hospital services include increases in units (volume) of service as measured by increases in inpatient hospital admissions covered under the HI program. Increases in admissions are attributable both to increases in enrollment under the HI program and to increases in admission incidence (admissions per beneficiary). The historical and projected increases in enrollment reflect the more rapid increase in the population aged 65 and over than in the total population of the United States, and the coverage of certain disabled beneficiaries and persons with end-stage renal disease. Increases in the enrollment are expected to continue, reflecting a continuation of demographic shift into categories of the population which are eligible for HI protection. In addition, increases in the average age of beneficiaries lead to higher levels of

admission incidence. Admission incidence levels are also often affected by changes in the laws and regulations that define and guide the HI program's coverage of inpatient hospital care.

c. Skilled Nursing Facility (SNF), Home Health Agency (HHA), and Hospice Costs

Historical experience with the number of days of care covered in SNFs under the HI program has been characterized by wide swings. The number of covered days dropped very sharply in 1970 and continued to decline through 1972. This was the result of strict enforcement of regulations separating skilled nursing care from custodial care. Because of the small fraction of nursing home care covered under the program, this reduction primarily reflected the determination that Medicare was not liable for payment rather than reduced usage of services. The 1972 amendments extended benefits to persons who require skilled rehabilitative services regardless of their need for skilled nursing services (the former prerequisite for benefits). This change and subsequent related changes in regulations have resulted in significant increases in the number of services covered by the program. More recently, changes made in 1988 to coverage guidelines for SNF services and expansions and changes due to the Medicare Catastrophic Coverage Act of 1988, effective January 1, 1989, resulted in large increases in utilization of SNF services. For 1990, the estimates contained in this report reflect a reduction in utilization consistent with the SNF transition provisions of the Medicare Catastrophic Coverage Repeal Act of 1989; for 1991, the complete repeal of the catastrophic expansions and changes are reflected. From 1991 to 1994, large increases in SNF utilization occurred. Increases are projected to gradually decline through 1996, eventually resulting in modest increases in covered days, based on growth and aging of the population.

Increases in the average cost per day (where cost is defined to be the total of program reimbursement and beneficiary cost sharing) in skilled nursing facilities under the program are caused principally by increasing payroll costs for nurses and other required skilled labor. For 1991 through 1994, extremely large rates of increase in cost per day occurred due to nursing home reform regulations. Projected rates of increase in cost per day are assumed to gradually decline to be slightly lower than increases in general earnings throughout the projection period, but adjustments to reflect regulations limiting SNF cost per day are included where appropriate. Increases in reimbursement per day reflect the changes in beneficiary cost sharing

amounts, including those changes resulting from the catastrophic coverage and catastrophic coverage repeal legislation.

The resulting increases in expenditures for SNF services are shown in Table II.D2.

TABLE II.D2. -- RELATIONSHIP BETWEEN INCREASES IN HI PROGRAM EXPENDITURES AND INCREASES IN TAXABLE PAYROLL ¹
(Percent)

Calendar year	Inpatient hospital ^{2,3}	Skilled nursing facility ³	Home health agency ³	Weighted average ^{3,4}	HI administrative costs ^{3,5}	HI program expenditures ^{3,5}	HI taxable payroll	Ratio of expenditures to payrolls ⁶
1995	6.9%	20.8%	18.1%	9.5%	-3.5%	9.3%	5.9%	3.2%
2000	8.3	6.8	6.6	8.0	6.0	8.0	5.2	2.7
2005	8.0	6.8	6.2	7.7	5.9	7.6	5.9	1.7
2010	7.8	6.5	5.9	7.5	6.0	7.5	5.7	1.7
2015	8.5	6.8	6.2	8.1	6.6	8.1	5.4	2.5
2019	8.5	7.4	6.8	8.2	6.6	8.2	5.2	2.9

¹Percent increase in year indicated over previous year, under the intermediate assumptions.

²This column may differ slightly from the last column of Table II.D1, since Table II.D1 includes all persons eligible for HI protection while this table excludes noninsured persons.

³Costs attributable to insured beneficiaries only, on an incurred basis. Benefits and administrative costs for noninsured persons are expected to be financed through general revenue transfers and premium payments, rather than through payroll taxes.

⁴Includes costs for hospice care.

⁵Includes costs of Peer Review Organizations.

⁶Percent increase in the ratio of program expenditures to taxable payroll. This is equivalent to the differential between the increase in program costs and the increase in taxable payroll.

Program experience with HHA payments has shown a generally upward trend. The number of visits had increased sharply from year to year, but some decreases, albeit small in magnitude relative to past increases, were experienced in the mid-1980's; these were followed by modest increases. Recently, however, extremely large increases in the number of visits have occurred, and this trend is projected to gradually decline through 1996. Modest increases, based on growth and aging of the population, are projected thereafter. Reimbursement per visit is assumed to increase at a slightly lower rate than increases in general earnings, but adjustments to reflect regulations limiting HHA reimbursement per visit are included where appropriate. The resulting increases in expenditures for HHA services are shown in Table II.D2.

Technical Section

Coverage of certain hospice care for terminally ill beneficiaries is a relatively new program benefit, resulting from the enactment of the Tax Equity and Fiscal Responsibility Act of 1982, and payments for hospice care are very small relative to total program benefit payments. Although detailed hospice data are scant at this time, estimates for hospice benefit payment increases are based on mandated daily payment rates and annual payment caps, and assume modest growth in the number of covered days. Increases in hospice payments are not shown separately in Table II.D2 due to their extremely small contribution to the weighted average increase for all HI types of service, but are included in the average.

d. Administrative Expenses

The cost of administering the HI program has remained relatively small, in comparison with benefit amounts, throughout the history of the program. The ratio of administrative expenses to benefit payments has generally fallen within the range of 1 to 3 percent. The short-range projection of administrative cost is based on estimates of workloads and approved budgets for intermediaries and the Health Care Financing Administration. In the long-range, administrative cost increases are based on assumed increases in workloads, primarily due to growth and aging of the population, and on assumed unit cost increases of slightly less than the increases in average hourly earnings shown in Table II.D1.

3. Financing Analysis Methodology

In order to analyze costs and to evaluate the financing of a program supported by payroll taxes, program costs must be compared on a year-by-year basis with the taxable payroll which provides most of the source of income for these costs. Since the vast majority of total program costs are related to insured beneficiaries and since general revenue appropriations and premium payments are expected to support the uninsured segments, the remainder of this report will focus on the financing for insured beneficiaries.

a. Taxable Payroll

Taxable payroll increases can be separated into a part due to increases in covered earnings and a part due to increases in the number of covered workers. The taxable payroll projection used in this report is based on

economic assumptions consistent with those used in the OASDI report. Increases in taxable payroll assumed for this report are shown in Table II.D2.

b. Relationship Between Program Costs and Taxable Payroll

The single most meaningful measure of program cost increases, with reference to the financing of the system, is the relationship between program cost increases and taxable payroll increases. If program costs increase more rapidly than taxable payroll, either increasing income rates or reducing program costs (or some combination thereof) will be required to finance the system in the future. Table II.D2 shows the resulting increases in program costs relative to taxable payroll over the first 25-year projection period. These relative increases reduce gradually to a level of about 2 percent per year by 2010, but increase to a level of about 3 percent per year by 2019 for the intermediate assumption, just after the post-World War II baby boom population starts becoming eligible for benefits. The result of these increases is a continued increase in the year-by-year ratios of program expenditures to taxable payroll, as shown in Table II.D3.

TABLE II.D3. -- SUMMARY OF ALTERNATIVE PROJECTIONS FOR THE HI PROGRAM
(Percent)

Calendar year	Increases in aggregate HI inpatient hospital payments ¹				Changes in the relationship between expenditures and payroll ¹			
	Average hourly earnings	CPI	Other factors ²	Total ³	Program expenditures ^{3,4,5}	Taxable payroll	Ratio of expenditures to payroll	Expenditures as a percent of taxable payroll ^{3,4,5}
Intermediate:								
1995	3.9%	3.1%	3.1%	6.8%	9.3%	5.9%	3.2%	3.26%
2000	4.3	3.7	4.0	8.3	8.0	5.2	2.7	3.77
2005	5.2	4.0	3.1	8.0	7.6	5.9	1.7	4.17
2010	5.2	4.0	2.8	7.8	7.5	5.7	1.7	4.57
2015	5.2	4.0	3.5	8.5	8.1	5.4	2.5	5.15
2019	5.2	4.0	3.5	8.5	8.2	5.2	2.9	5.73

TABLE II.D3. -- SUMMARY OF ALTERNATIVE PROJECTIONS FOR THE HI PROGRAM
(Percent)

Calendar year	Increases in aggregate HI inpatient hospital payments ¹				Changes in the relationship between expenditures and payroll ¹			
	Average hourly earnings	CPI	Other factors ²	Total ³	Program expenditures ^{3,4,5}	Taxable payroll	Ratio of expenditures to payroll	Expenditures as a percent of taxable payroll ^{3,4,5}
Low Cost:								
1995	4.0%	2.7%	2.8%	6.4%	9.0%	6.6%	2.3%	3.23%
2000	4.4	3.0	2.6	6.6	6.7	5.6	1.1	3.44
2005	4.4	3.0	1.5	5.5	5.7	5.4	0.2	3.53
2010	4.6	3.0	1.3	5.4	5.5	5.3	0.2	3.57
2015	4.6	3.0	1.8	6.0	6.0	5.1	0.9	3.73
2019	4.6	3.0	1.9	6.1	6.2	4.9	1.3	3.89
High Cost:								
1995	3.7%	3.6%	3.1%	6.9%	9.4%	5.4%	3.8%	3.28%
2000	5.0	5.0	5.3	10.6	9.9	5.5	4.2	4.14
2005	6.1	5.0	4.5	10.5	9.8	6.3	3.2	4.92
2010	5.9	5.0	4.5	10.4	9.7	6.1	3.4	5.85
2015	5.9	5.0	5.1	11.0	10.3	5.8	4.3	7.17
2019	5.9	5.0	5.1	11.0	10.5	5.5	4.7	8.55

¹Percent increase in the year indicated over the previous year.

²Other factors include hospital hourly earnings, hospital price input intensity, unit input intensity allowance, units of service as measured by admissions, and other sources.

³On an incurred basis.

⁴Includes expenditures attributable to insured beneficiaries only.

⁵Includes costs of Peer Review Organizations.

4. Sensitivity Testing of Costs Under Alternative Assumptions

Since the beginning of the program, aggregate inpatient hospital costs for Medicare beneficiaries have increased substantially faster than increases in average earnings and prices in the general economy. Table II.D1 shows the estimated experience of the HI program for 1984 to 1993. As mentioned earlier, the HI program now makes payments to most participating hospitals on a prospective basis (with the exception of certain expenses). The prospective payment system has made the outlays of the HI program potentially less vulnerable to excessive rates of growth in the hospital industry. However, there is some uncertainty in projecting HI expenditures, for inpatient hospital services as well as the other covered types of services, due to the uncertainty of the underlying economic assumptions and utilization increases. In addition, there is uncertainty in projecting HI expenditures due to the possibility of future legislation affecting unit payment levels, particularly

for inpatient hospital services. Current law is assumed throughout the estimates shown in this report, but legislation affecting the payment levels to hospitals has been enacted nearly annually for about the past 10 years, and future legislation is probable.

In view of the uncertainty of future cost trends, projected costs for the HI program have been prepared under three alternative sets of assumptions. A summary of the assumptions and results is shown in Table II.D3. The set of assumptions labeled "Intermediate" forms the basis for the detailed discussion of hospital cost trends and resulting program costs presented throughout this report. It represents intermediate cost increase assumptions, compared with the lower cost and higher cost alternatives. Increases in the economic factors (average hourly earnings and CPI) for the three alternatives are consistent with those underlying the OASDI report.

As noted earlier, the single most meaningful measure of HI program cost increases, with reference to the financing of the system, is the relationship between program cost increases and taxable payroll increases. The extent to which program cost increases exceed increases in taxable payroll will determine how steeply income rates must be increased or program costs curtailed to finance the system over time.

By the end of the first 25-year projection period, program costs are projected to increase about 3 percent faster per year than increases in taxable payroll for the intermediate assumption, as discussed in the "Financing Analysis Methodology" section. Program costs beyond the first 25-year projection period are based on the assumption that costs per unit of service increase at the same rate as average hourly earnings increase. Program expenditures, which were about 3 percent of taxable payroll in 1994, increase to a level of about 6 percent by the year 2019 and to over 10 percent by the year 2069 under the intermediate assumptions. Hence, if all of the projection assumptions are realized over time, the HI income rates provided in current law (3.2 percent of taxable payroll) will be grossly inadequate to support the cost of the program.

During the first 25-year projection period, the low cost and high cost alternatives contain assumptions which result in program costs increasing, relative to taxable payroll increases, approximately 2 percent less rapidly and 2 percent more rapidly, respectively, than the results under the intermediate assumptions. Costs beyond the first 25-year projection period assume the 2 percent differential gradually decreases until the year 2044 when program cost

increases relative to taxable payroll are approximately the same as under the intermediate assumptions. Under the low cost alternative, program costs increase about 0.8 percent more per year than increases in taxable payroll during the first 25-year projection period. Program expenditures under this alternative would be about 3.9 percent of taxable payroll in the year 2019, increasing to about 5.3 percent of taxable payroll by 2069. The summarized program cost rate for the 75-year projection period is about 4.1 percent of taxable payroll and the summarized income rate is about 3.1 percent of taxable payroll; hence, HI income rates provided in current law will be inadequate even under the low cost alternative. Under the high cost alternative, program costs increase about 4.1 percent more rapidly per year than increases in taxable payroll during the first 25-year projection period. The result of this differential is a level of program expenditures in the year 2019 which is about 8.6 percent of taxable payroll, increasing to about 19.4 percent of taxable payroll in the year 2069. The summarized program cost rate for the 75-year projection period is about 11.3 percent of taxable payroll. The summarized income rate is about 3.2 percent of taxable payroll.

E. LONG-RANGE SENSITIVITY ANALYSIS

This section presents estimates which illustrate the sensitivity of the long-range cost rate and actuarial balance of the HI program to changes in selected individual assumptions. The estimates based on the three alternative sets of assumptions (i.e., intermediate, low cost, and high cost) illustrate the effects of varying all of the principal assumptions simultaneously in order to portray a generally more optimistic or pessimistic future, in terms of the projected financial status of the HI program. In the sensitivity analysis presented in this section, the intermediate set of assumptions is used as the reference point, and one assumption at a time is varied within that alternative. Similar variations in the selected assumptions within the other alternatives would result in similar variations in the long-range estimates.

Each table that follows shows the effects of changing a particular assumption on the HI summarized income rates, summarized cost rates, and actuarial balances (as defined earlier in this report) for 25-year, 50-year, and 75-year valuation periods. Because the income rate varies only slightly with changes in assumptions, it is not considered in the discussion of the tables. The change in each of the actuarial balances is approximately equal to the change in the corresponding cost rate, but in the opposite direction. For example, a

lower projected cost rate would result in an improvement in the corresponding projected actuarial balance.

1. Real-Wage Differential

Table II.E1 shows the estimated HI income rates, cost rates, and actuarial balances on the basis of the intermediate assumptions with various assumptions about the real-wage differential. These assumptions are that the ultimate real-wage differential will be 0.5-percentage-point (as assumed for the high cost alternative), 1.0-percentage-point (as assumed for the intermediate assumptions), and 1.5-percentage-points (as assumed for the low cost alternative). In each case, the ultimate annual increase in the CPI is assumed to be 4.0 percent (as assumed for the intermediate assumptions), yielding ultimate percentage increases in average annual wages in covered employment of 4.5, 5.0, and 5.5 percent under the high cost, intermediate, and low cost alternatives, respectively.

Past increases in real earnings have exhibited substantial variation. During 1951-1970, real earnings grew by an average of 2.2 percent per year. During the last quarter century, however, the average annual increase in real earnings has amounted to only 0.1 percent. The possibility of continuing poor performance in real wage growth is a matter of some concern to analysts and policymakers. Thus, the sensitivity of HI costs to future real wage growth is important. As shown in Table II.E1, projected HI costs are, in fact, fairly sensitive to the assumed growth rates in real wages. For the 75-year period 1995-2069, the summarized cost rate decreases from 7.07 percent (for a real-wage differential of 0.5 percentage point) to 6.33 percent (for a differential of 1.5 percentage points). The HI actuarial balance over this period shows a corresponding improvement for faster rates of growth in real wages.

TABLE II.E1. -- ESTIMATED HI INCOME RATES, COST RATES, AND ACTUARIAL BALANCES, BASED ON INTERMEDIATE ESTIMATES WITH VARIOUS REAL-WAGE ASSUMPTIONS
(As a percentage of taxable payroll)

Valuation period	Ultimate percentage increase in wages-CPI ¹		
	4.5-4.0	5.0-4.0	5.5-4.0
Summarized income rate:			
25-year: 1995-2019	3.05	3.04	3.03
50-year: 1995-2044	3.14	3.12	3.10
75-year: 1995-2069	3.18	3.16	3.14
Summarized cost rate:			
25-year: 1995-2019	4.51	4.37	4.26
50-year: 1995-2044	6.06	5.79	5.57
75-year: 1995-2069	7.07	6.69	6.33
Actuarial balance:			
25-year: 1995-2019	-1.46	-1.33	-1.23
50-year: 1995-2044	-2.92	-2.68	-2.47
75-year: 1995-2069	-3.89	-3.52	-3.19

¹ The first value in each pair is the assumed ultimate annual percentage increase in average wages in covered employment. The second value is the assumed ultimate annual percentage increase in the Consumer Price Index. The difference between the two values is the real-wage differential.

The HI cost rate decreases with increasing real-wage differentials, because the higher real-wage levels increase the taxable payroll to a greater extent than they increase HI program benefits. In particular, each 0.5-percentage-point increase in the assumed real-wage differential increases the long-range HI actuarial balance on average by about 0.35 percent of taxable payroll.⁴

2. Consumer Price Index

Table II.E2 shows the estimated HI income rates, cost rates, and actuarial balances on the basis of the intermediate alternative with various assumptions about the rate of increase for the Consumer Price Index (CPI). These assumptions are that the ultimate annual increase in the CPI will be 3.0 percent (as assumed for the low cost alternative), 4.0 percent (as assumed for the intermediate assumptions), and 5.0 percent (as assumed for the high cost

⁴ This sensitivity is dampened somewhat because, as noted previously in this report, after the first 25 years medical care costs are assumed to increase at the same rate as average hourly earnings. As a result, assumed faster real wage growth causes projected taxable payroll to increase more rapidly than projected costs, but only for the first 25 years. Thereafter, payroll and costs are both projected to increase at about the same rate. The cumulative change between payroll and costs continues but does not increase further.

alternative). In each case, the ultimate real-wage differential is assumed to be 1.0 percent (as assumed for the intermediate assumptions), yielding ultimate percentage increases in average annual wages in covered employment of 4.0, 5.0, and 6.0 percent under the low cost, intermediate, and high cost alternatives, respectively.

TABLE II.E2. -- ESTIMATED HI INCOME RATES, COST RATES, AND ACTUARIAL BALANCES, BASED ON INTERMEDIATE ESTIMATES WITH VARIOUS CPI-INCREASE ASSUMPTIONS

(As a percentage of taxable payroll)

Valuation period	Ultimate percentage increase in wages-CPI ¹		
	4.0-3.0	5.0-4.0	6.0-5.0
Summarized income rate:			
25-year: 1995-2019	3.04	3.04	3.03
50-year: 1995-2044	3.12	3.12	3.10
75-year: 1995-2069	3.16	3.16	3.14
Summarized cost rate:			
25-year: 1995-2019	4.40	4.37	4.34
50-year: 1995-2044	5.86	5.79	5.74
75-year: 1995-2069	6.78	6.69	6.63
Actuarial balance:			
25-year: 1995-2019	-1.36	-1.33	-1.31
50-year: 1995-2044	-2.74	-2.68	-2.64
75-year: 1995-2069	-3.62	-3.52	-3.49

¹The first value in each pair is the assumed ultimate annual percentage increase in average wages in covered employment. The second value is the assumed ultimate annual percentage increase in the Consumer Price index.

For all three periods, the cost rate decreases slightly with greater assumed rates of increase in the CPI. Over the 75-year projection period, for example, the cost rate decreases from 6.78 percent (for CPI increases of 3.0 percent) to 6.63 percent (for CPI increases of 5.0 percent). The relative insensitivity of projected HI cost rates to different levels of general inflation occurs because inflation is assumed to affect both the taxable payroll of workers and medical care costs about equally.⁵ In practice, differing rates of inflation could occur between the economy in general and the medical-care sector. The effect of such a difference can be judged from the sensitivity analysis shown in the subsequent section on miscellaneous health care cost factors. The effect of each 1.0-percentage-point increase in the rate of change assumed

⁵ The slight sensitivity shown results primarily from the fact that the fiscal year 1995 payment rates for hospitals have already been set. If the 1995 payments were allowed to be affected by CPI changes, there would be no projected effect due to CPI changes.

for the CPI is an increase in the long-range actuarial balance of about 0.06 percent of taxable payroll, on average.

3. Real-Interest Rate

Table II.E3 shows the estimated HI income rates, cost rates, and actuarial balances under the intermediate alternative with various assumptions about the annual real-interest rate for special public-debt obligations issuable to the trust fund. These assumptions are that the ultimate annual real-interest rate will be 1.5 percent (as assumed for the high cost alternative), 2.3 percent (as assumed for the intermediate assumptions), and 3.0 percent (as assumed for the low cost alternative). In each case, the ultimate annual increase in the CPI is assumed to be 4.0 percent (as assumed for the intermediate assumptions), resulting in ultimate annual yields of 5.6, 6.4, and 7.1 percent under the high cost, intermediate, and low cost alternatives, respectively.

TABLE II.E3. -- ESTIMATED HI INCOME RATES, COST RATES, AND ACTUARIAL BALANCES, BASED ON INTERMEDIATE ESTIMATES WITH VARIOUS REAL-INTEREST ASSUMPTIONS
(As a percentage of taxable payroll)

Valuation period	Ultimate annual real-interest rate		
	1.5 percent	2.3 percent	3.0 percent
Summarized income rate:			
25-year: 1995-2019	3.04	3.04	3.03
50-year: 1995-2044	3.13	3.12	3.11
75-year: 1995-2069	3.18	3.16	3.14
Summarized cost rate:			
25-year: 1995-2019	4.44	4.37	4.32
50-year: 1995-2044	6.04	5.79	5.61
75-year: 1995-2069	7.10	6.69	6.38
Actuarial balance:			
25-year: 1995-2019	-1.40	-1.33	-1.29
50-year: 1995-2044	-2.91	-2.68	-2.50
75-year: 1995-2069	-3.92	-3.52	-3.24

For all periods, the cost rate decreases with increasing real-interest rates. Over 1995-2069 for example, the summarized HI cost rate would decline from 7.10 percent (for an ultimate real-interest rate of 1.5 percent) to 6.38 percent (for an ultimate real-interest rate of 3.0 percent). Thus, each 1.0-percentage-point increase in the assumed real-interest rate increases the long-range actuarial balance on average by about 0.45 percent of taxable payroll. The fact that the actuarial balance of the HI program is sensitive to the interest

assumption is not an indication of the actual role that interest plays in the financing of the HI program. In actuality, interest finances very little of the cost of the HI program. The sensitivity of the actuarial balance to the interest assumption is implicit in the present-value method used to calculate the actuarial balance (as described in more detail in Appendix A).

4. Health Care Cost Factors

Table II.E4 shows the estimated HI income rates, cost rates, and actuarial balances on the basis of the intermediate set of assumptions with two variations on the relative annual growth rate in the aggregate cost of providing covered health care services to HI beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to the growth in taxable payroll, will be 1 percent slower than the intermediate assumption, the same as the intermediate assumption, and 1 percent faster than the intermediate assumption. In each case, the taxable payroll will be the same as assumed for the intermediate assumptions.

As noted previously, factors such as wage increases and price increases may simultaneously affect both HI tax income and the costs incurred by hospitals and other providers of medical care to HI beneficiaries. (The sensitivity of the program's financial status to these factors is evaluated in sections 1 and 2 of this chapter.) Other factors, such as the utilization of services by beneficiaries or the relative complexity of the services provided, can affect provider costs without affecting HI tax income. The sensitivity analysis shown in Table II.E4 illustrates the financial effect of any combination of such factors that results in aggregate provider costs increasing by 1 percent faster or slower than the intermediate assumptions, relative to growth in taxable payroll under the intermediate assumptions.

TABLE II.E4. -- ESTIMATED HI INCOME RATES, COST RATES, AND ACTUARIAL BALANCES, BASED ON INTERMEDIATE ESTIMATES WITH VARIOUS HEALTH CARE COST GROWTH RATE ASSUMPTIONS
(As a percentage of taxable payroll)

Valuation period	Annual cost/payroll relative growth rate		
	-1 percent	0 percent	+1 percent
Summarized income rate:			
25-year: 1995-2019	3.04	3.04	3.04
50-year: 1995-2044	3.12	3.12	3.12
75-year: 1995-2069	3.16	3.16	3.16
Summarized cost rate:			
25-year: 1995-2019	3.83	4.37	5.01
50-year: 1995-2044	4.44	5.79	7.68
75-year: 1995-2069	4.59	6.69	10.11
Actuarial balance:			
25-year: 1995-2019	-0.78	-1.33	-1.97
50-year: 1995-2044	-1.32	-2.68	-4.56
75-year: 1995-2069	-1.42	-3.52	-6.95

As illustrated in Table II.E4, the financial status of the HI program is extremely sensitive to the relative growth rates for health care service costs versus taxable payroll.⁶ For the 75-year period, the cost rate increases from 4.59 percent (for an annual cost/payroll growth rate of 1 percent less than the intermediate assumptions) to 10.11 percent (for an annual cost/payroll growth rate of 1 percent more than the intermediate assumptions). Each 1.0-percentage-point increase in the assumed cost/payroll relative growth rate decreases the long-range actuarial balance on average by about 2.76 percent of taxable payroll.

⁶ In contrast to the situation described for the real-wage differential (see footnote 4), the sensitivity analysis shown here reflects the continuing effects of relatively faster or slower growth in medical care costs throughout the entire 75-year period. As a result, the sensitivity shown here for miscellaneous health care cost factors is substantially greater than shown for the real-wage differential.

III. APPENDICES

A. ACTUARIAL BALANCE UNDER THE MODIFIED AVERAGE-COST METHOD

In section I.D, the summarized income rates, cost rates, and actuarial balances are presented based on the actuarial present values of future income, costs, and taxable payrolls. Such methods are widely used in actuarial, economic, and financial analyses. In effect, the present value calculation applies successively less weight to the projected values as the projection interval lengthens. This technique reflects the fact that the value of the dollar changes over time -- in particular, a dollar available today can earn interest over time and is therefore more valuable than the same dollar available in some future year.

The actuarial balance computed under the present-value method can be interpreted as the immediate, level, and permanent percentage that, if added to the current law income rates and/or subtracted from the current law cost rates throughout the valuation period, would provide sufficient financing to support program costs throughout the period and would leave the targeted trust fund balance at the end of the projection period. If such a policy were followed, a large fund would accumulate and would earn substantial interest credits, significantly exceeding those that would be earned under current law financing.

The measurement of the actuarial balance by the present-value method is significantly affected by the level of assumed future interest rates (as illustrated in section II.E.3 of this report). The higher the assumed rate of interest, the lower the weight that is applied to the more distant, high-cost years of the projection. (Equivalently, the greater the amount of interest that would be earned if a large fund were accumulated.) In practice, however, unless a large fund is accumulated, interest earnings will play a relatively small role in the financing of the HI program. The sensitivity of the actuarial balance to assumed interest rates is not readily apparent from a casual inspection of the actuarial deficit as measured by the present-value method.

An alternative to the present-value method, called the modified average-cost method, was used prior to 1988 to evaluate the actuarial status of the program. Under this method, the actuarial balance is defined as the difference between the arithmetic means of the annual cost rates (as defined in section I.D) and the annual income rates. Thus, under this method, the cost rates and income rates for each year are given equal weights when

summarized into a single measure. The annual cost rates include an amount to maintain the trust fund at a desired target level, if the fund would otherwise drop below that level at any point within the projection period. In addition, the actuarial balances calculated under the modified average-cost method reflect the starting trust fund balance and the interest earned on the trust fund before it is exhausted.

The actuarial balance using the modified average-cost method can be characterized as the average of the annual income rate increases needed to maintain the trust fund at the target level over each year of the 75-year projection period, taking into account the beginning trust fund balance and the interest earnings of the trust fund. The implied funding pattern under the modified average-cost method is that the current law trust fund ratios would be maintained until the trust fund ratio falls below the target amount (100 percent of the following year's estimated expenditures, in this year's report). After that, the income rate would be increased each year to cover the cost of the program and to maintain the trust fund at the target level. This measure of the actuarial balance is relatively insensitive to the assumed future interest rates, in keeping with the minor role that interest plays in the financing of a program on a current-cost or pay-as-you-go basis.

The actuarial balance using the modified average-cost method, under the Trustees' intermediate assumptions, is -3.93 percent of taxable payroll as compared to -3.52 percent based on the present-value method. Based on either measure, the actuarial deficit represents roughly 50 percent of the summarized cost rate. Thus, the HI trust fund fails the Trustees' test of long-range close actuarial balance by a wide margin using either measure. Table III.A1 shows the summarized HI projections based on the modified average-cost method under the three alternative sets of assumptions.

TABLE III.A1. -- ACTUARIAL BALANCES OF THE HI PROGRAM, UNDER THREE SETS OF ASSUMPTIONS (MODIFIED AVERAGE-COST METHOD)

	Intermediate assumptions	Alternative	
		Low Cost	High Cost
Projection Periods:			
1995-2019:			
Summarized Income rate ¹	3.05%	3.03%	3.06%
Summarized cost rate ²	4.42	3.52	5.65
Actuarial balance ³	-1.38	-0.49	-2.58
1995-2044:			
Summarized Income rate ¹	3.13	3.09	3.17
Summarized cost rate ²	6.03	3.91	9.72
Actuarial balance ³	-2.90	-0.82	-6.55
1995-2069:			
Summarized income rate ¹	3.18	3.12	3.26
Summarized cost rate ²	7.11	4.25	12.41
Actuarial balance ³	-3.93	-1.13	-9.15

¹Under present law.²Expenditures for benefit payments and administrative costs for insured beneficiaries, on an incurred basis, expressed as a percentage of taxable payroll, computed on the modified average-cost basis, including the cost of maintaining the trust fund at a level of 100% of the following year's estimated expenditures, and including an offset to cost due to the beginning trust fund balance.³Difference between the summarized income rate and the summarized cost rate.

B. MEDICARE INCURRED DISBURSEMENTS AS A PERCENT OF GROSS DOMESTIC PRODUCT FROM CALENDAR YEAR 1994 TO 2069

Medicare incurred disbursements as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. For these purposes, incurred disbursements are the sum of the incurred benefit and administrative expenses. The projection of this relative measure of disbursements affords the public an idea of the relative financial resources that will be necessary to pay for Medicare services.

Table III.B1 shows estimated incurred disbursements for the HI and SMI programs under the intermediate assumptions expressed as a percentage of GDP, for selected years over the period 1994-2069. These incurred disbursements assume no change in current law for any specific program legislation or for any comprehensive health care reform. The 75-year projection period fully allows for the presentation of future contingencies that reasonably may be expected to occur, such as the impact of a large increase in enrollees which occurs after the turn of the century. This large increase in enrollees occurs because the relatively large number of persons born during the period between the end of World War II and the mid-1960's (known as the baby boom) will reach retirement age and begin to receive benefits.

Table III.B1. -- HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE INCURRED DISBURSEMENTS AS A PERCENT OF GROSS DOMESTIC PRODUCT¹

Calendar year	Disbursements as a percent of GDP		
	HI	SMI	Total
1994	1.56	0.93	2.49
1995	1.62	0.99	2.61
2000	1.87	1.30	3.17
2005	2.05	1.70	3.75
2010	2.23	2.27	4.50
2015	2.50	2.81	5.31
2020	2.83	3.18	6.01
2025	3.21	3.59	6.80
2030	3.57	3.92	7.49
2035	3.82	4.09	7.91
2040	3.97	4.08	8.05
2045	4.05	4.01	8.06
2050	4.10	3.97	8.07
2055	4.16	4.00	8.16

Table III.B1. -- HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE INCURRED DISBURSEMENTS AS A PERCENT OF GROSS DOMESTIC PRODUCT¹

Calendar year	Disbursements as a percent of GDP		
	HI	SMI	Total
2060	4.25	4.12	8.37
2065	4.36	4.23	8.59
2069	4.46	4.29	8.75

¹Disbursements are the sum of benefit payments and administrative expenses.

For HI, program costs beyond the first 25-year projection period are based on the assumption that costs per unit of service will increase at the same rate as average hourly earnings increase. The associated aggregate disbursements are then represented as a percentage of GDP. For SMI, increases in the costs per enrollee during the initial 25-year period are assumed to gradually decline in the last 12 years to the same rate as GDP per capita and then to continue at the same rate as GDP per capita in the last 50 years. Given the historical experience of SMI costs per enrollee increasing faster than GDP per capita, the assumption of the increases in costs per enrollee declining to the same rate as GDP per capita may be considered optimistic because changes in the last 50 years of the estimation period reflect only the impact of the changing demographic composition of the population.

Based on these assumptions, incurred Medicare disbursements as a percent of GDP are projected to increase rapidly from 2.49 percent in 1994 to 7.91 percent in 2035 and then to increase gradually to 8.75 percent in 2069. After 2035, while Medicare disbursements as a percent of GDP increase more slowly, the HI percentage grows steadily while the SMI percentage decreases slightly to about 2050 and then increases again to 2069.

C. ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) INPATIENT HOSPITAL DEDUCTIBLE AND HOSPITAL AND EXTENDED CARE SERVICES COINSURANCE AMOUNTS, FOR CALENDAR YEAR 1995¹

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year 1995 under Medicare's hospital insurance program (Medicare Part A). The Medicare statute specifies the formulae to be used to determine these amounts.

The inpatient hospital deductible will be \$716. The daily coinsurance amounts will be: (a) \$179 for the 61st through 90th days of hospitalization in a benefit period; (b) \$358 for lifetime reserve days; and (c) \$89.50 for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period.

Effective Date: January 1, 1995.

SUPPLEMENTARY INFORMATION:

1. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires the Secretary to determine and publish between September 1 and September 15 of each year the amount of the inpatient

¹ Extracted from the notice entitled "Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 1995," which was published in the Federal Register on December 1, 1994 (Vol. 59, no. 230, pp. 61628-61629).

hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year.

2. Computing the Inpatient Hospital Deductible for 1995

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act). This estimate is used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding calendar year and adjusted to reflect real case mix. The adjustment to reflect real case mix is determined on the basis of the most recent case mix data available. The amount determined under this formula is rounded to the nearest multiple of \$4 (or, if midway between two multiples of \$4, to the next higher multiple of \$4).

For FY 1995, section 1886(b)(3)(B)(i)(IX) of the Act, as amended by section 13501 of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66, enacted on August 10, 1993), provides that the applicable percentage increase for urban prospective payment system hospitals is the market basket percentage increase minus 2.5 percent, and the applicable percentage increase for rural prospective payment system hospitals is the amount necessary to equalize the rural and other urban national average standardized amounts. Section 1886(b)(3)(B)(ii)(V) of the Act, as added by section 13502(a) of Public Law 103-66, provides that for FY 1995, the otherwise applicable rate-of-increase percentages (the market basket percentage increase) for hospitals that are excluded from the prospective payment system are reduced by the lesser of 1 percentage point or the percentage point difference between 10 percent and the percentage by which the hospital's allowable operating costs of inpatient hospital services for cost reporting periods beginning in FY 1990 exceeds the hospital's target amount. Hospitals or distinct part hospital units with FY 1990 operating costs exceeding target amounts by 10 percent or more receive the market basket index percentage. The market basket percentage increases for FY 1995 are 3.6 percent for prospective payment system hospitals and 3.7 percent for hospitals excluded from the prospective payment system, as announced in the **Federal Register** on September 1, 1994 (59 FR 45330). Therefore, the percentage increases for Medicare prospective payment rates are 1.1 percent for urban hospitals and 8.4 percent for rural hospitals. The average payment percentage increase for hospitals excluded

from the prospective payment system is 3.13 percent, computed as required by section 13502 of Public Law 103-66. Thus, weighting these percentages in accordance with payment volume, the Secretary's best estimate of the payment-weighted average of the increases in the payment rates for FY 1995 is 1.92 percent.

To develop the adjustment for real case mix, an average case mix was first calculated for each hospital that reflects the relative costliness of that hospital's mix of cases compared to that of other hospitals. We then computed the increase in average case mix for hospitals paid under the Medicare prospective payment system in FY 1994 compared to FY 1993. (Hospitals excluded from the prospective payment system were excluded from this calculation since their payments are based on reasonable costs and are affected only by real increases in case mix.) We used bills from prospective payment hospitals received in HCFA as of the end of July 1994. These bills represent a total of about 8 million discharges for FY 1994 and provide the most recent case mix data available at this time. Based on these bills, the increase in average case mix in FY 1994 is 0.33 percent. Based on past experience, we expect overall case mix to increase to 0.85 percent as the year progresses and more FY 1994 data becomes available.

Section 1813 of the Act requires that the inpatient hospital deductible be increased only by that portion of the case mix increase that is determined to be real. We estimate that the increase in real case mix is about 0.85 percent. This assumes that all of the increase in case mix is real.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 1.92 percent, and the real case mix adjustment factor for the deductible is 0.85 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in calendar year 1995 is \$716. This deductible amount is determined by multiplying \$696 (the inpatient hospital deductible for 1994) by the payment rate increase of 1.0192 multiplied by the increase in real case mix of 1.0085 which equals \$715.39 and is rounded to \$716.

3. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 1995

The coinsurance amounts provided for in section 1813 of the Act are defined as fixed percentages of the inpatient hospital deductible for services furnished in the same calendar year. Thus, the increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in 1995, in accordance with the fixed percentages defined in the law, the daily coinsurance for the 61st through 90th days of hospitalization in a benefit period will be \$179 (1/4 of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be \$358 (1/2 of the inpatient hospital deductible); and the daily coinsurance for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period will be \$89.50 (1/8 of the inpatient hospital deductible).

4. Cost to Beneficiaries

We estimate that in 1995 there will be about 9.2 million deductibles paid at \$716 each, about 3.6 million days subject to coinsurance at \$179 per day (for hospital days 61 through 90), about 1.6 million lifetime reserve days subject to coinsurance at \$358 per day, and about 18.6 million extended care days subject to coinsurance at \$89.50 per day. Similarly, we estimate that in 1994 there will be about 8.9 million deductibles paid at \$696 each, about 3.5 million days subject to coinsurance at \$174 per day (for hospital days 61 through 90), about 1.6 million lifetime reserve days subject to coinsurance at \$348 per day, and about 18.2 million extended care days subject to coinsurance at \$87 per day. Therefore, the estimated total increase in cost to beneficiaries is about \$530 million (rounded to the nearest \$10 million), due to (1) the increase in the deductible and coinsurance amounts and (2) the change in the number of deductibles and daily coinsurance amounts paid.

5. Regulatory Impact Statement

This notice merely announces amounts required by legislation. This notice is not a proposed rule or a final rule issued after a proposal and does not alter any regulation or policy. Therefore, we have determined, and the Secretary certifies, that no analyses are required under Executive Order 12866, the Regulatory Flexibility Act (5 U.S.C. 601 through 612), or section 1102(b) of the Act.

Dated: September 9, 1994.

Bruce C. Vladeck,
Administrator,
Health Care Financing Administration

Approved: September 9, 1994.

Donna E. Shalala,
Secretary

D. ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) MONTHLY PREMIUM RATE FOR THE UNINSURED AGED AND FOR CERTAIN DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT, FOR CALENDAR YEAR 1995¹

SUMMARY: This notice announces the hospital insurance premium for calendar year 1995 under Medicare's hospital insurance program (Part A) for the uninsured aged and for certain disabled individuals who have exhausted other entitlement. The monthly Medicare Part A premium for the 12 months beginning January 1, 1995 for these individuals is \$261. The reduced premium for certain other individuals as described in this notice is \$183. Section 1818(d) of the Social Security Act specifies the method to be used to determine these amounts.

Effective Date: January 1, 1995.

SUPPLEMENTARY INFORMATION:

1. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare hospital insurance program (Medicare Part A), subject to payment of a monthly premium, of certain persons who are age 65 and older, uninsured for social security or railroad retirement benefits and do not otherwise meet the requirements for entitlement to Medicare Part A. (Persons insured under the Social Security or Railroad Retirement Acts need not pay premiums for hospital insurance.)

Section 1818(d) of the Act requires the Secretary to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services performed and for related administrative costs incurred in the following year with respect to individuals age 65 and over who

¹Extracted from the notice entitled "Medicare Program; Part A Premium for 1995 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement," which was published in the Federal Register on December 1, 1994 (Vol. 59, No. 230, pp. 61626-61628).

will be entitled to benefits under Medicare Part A. The Secretary must then, during September of each year, determine the monthly actuarial rate (the per capita amount estimated above divided by 12) and publish the dollar amount to be applicable for the monthly premium in the succeeding year. If the premium is not a multiple of \$1, the premium is rounded to the nearest multiple of \$1 (or, if it is a multiple of 50 cents but not of \$1, it is rounded to the next highest \$1). The 1994 premium under this method was \$245 and was effective January 1994. (See 58 FR 58555; November 2, 1993.)

Section 1818(d)(2) of the Act requires the Secretary to determine and publish, during September of each calendar year, the amount of the monthly premium for the following calendar year for persons who voluntarily enroll in Medicare Part A.

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, of certain disabled individuals who have exhausted other entitlement. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act, continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because they had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the premium determined under section 1818(d)(2) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66, enacted on August 10, 1993) amended section 1818(d) of the Act to provide, for a reduction in the monthly premium amount for certain voluntary enrollees. The reduction applies for individuals who are not eligible for social security or railroad retirement benefits but who:

- (1) Had at least 30 quarters of coverage under title II of the Act;
- (2) Were married and had been married for the previous 1-year period to an individual who had at least 30 quarters of coverage;
- (3) Had been married to an individual for at least 1 year at the time of the individual's death and the individual had at least 30 quarters of coverage; or

- (4) Are divorced from an individual who at the time of the divorce had at least 30 quarters of coverage and the marriage lasted at least 10 years.

For calendar year 1995, section 1818(d)(4)(A), as added by section 13508 of Public Law 103-66 specifies that the monthly premium that these individuals will pay for calendar year 1995 will be equal to the monthly premium for aged voluntary enrollees reduced by 30 percent.

2. Premium Amount for 1995

Under the authority of sections 1818(d)(2) and 1818A(d)(2) of the Act, the Secretary has determined that the monthly Medicare Part A hospital insurance premium for the uninsured aged and for certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 1995 is \$261.

The monthly premium for those individuals entitled to a 30 percent reduction in the monthly premium for the 12-month period beginning January 1, 1995 is \$183.

3. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Premium Rate

As discussed in section 1 of this notice, the monthly Medicare Part A premium for 1995 is equal to the estimated monthly actuarial rate for 1995 rounded to the nearest multiple of \$1. The monthly actuarial rate is defined to be one-twelfth of the average per capita amount that the Secretary estimates will be paid from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in 1995 for individuals age 65 and over who will be entitled to benefits under the hospital insurance program. Thus, the number of individuals age 65 and over who will be entitled to hospital insurance benefits and the costs incurred on behalf of these beneficiaries must be projected to determine the premium rate.

The principal steps involved in projecting the future costs of the hospital insurance program are (a) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base; (b) projecting increases in payment amounts for each of the various service types; and (c) projecting increases in administrative costs. Establishing historical Medicare

Appendices

Part A enrollment and projecting future enrollment, by type of beneficiary, is part of this process.

We have completed all of the above steps, basing our projections for 1995 on (a) current historical data and (b) projection assumptions under current law from the Midsession Review of the President's Fiscal Year 1995 Budget, incorporating the provisions of Public Law 103-66. It is estimated that in calendar year 1995, 32.548 million people age 65 and over will be entitled to Medicare Part A benefits (without premium payment), and that these individuals will, in 1995, incur \$102.113 billion of benefits for services performed and related administrative costs. Thus, the estimated monthly average per capita amount is \$261.44 and the monthly premium is \$261. The monthly premium for those individuals eligible to pay this premium reduced by 30 percent is \$183.

4. Costs to Beneficiaries

The 1995 Medicare Part A premium is about 7 percent higher than the \$245 monthly premium amount for the 12-month period beginning January 1, 1994.

We estimate that there will be, in calendar year 1995, approximately 277,000 enrollees who will voluntarily enroll in Medicare Part A by paying the full premium and who do not otherwise meet the requirements for entitlement. An additional 5,000 enrollees will be paying the reduced premium. The estimated overall effect of the changes in the premium will be a cost to these voluntary enrollees of about \$50 million.

5. Regulatory Impact Statement

This notice merely announces amounts required by legislation. This notice is not a proposed rule or a final rule issued after a proposal, and does not alter any regulation or policy. Therefore, we have determined, and the Secretary certifies, that no analyses are required under Executive Order 12866, the Regulatory Flexibility Act (5 U.S.C. 601 through 612) or section 1102(b) of the Act.

Dated: September 27, 1994.

**Bruce Vladeck,
Administrator,
Health Care Financing Administration**

Approved: October 20, 1994.

**Donna E. Shalala,
Secretary**

E. GLOSSARY

Actuarial balance. The difference between the summarized income rate and the summarized cost rate over a given valuation period.

Actuarial deficit. A negative actuarial balance.

Administrative expenses. Expenses incurred by the Department of HHS and the Department of the Treasury in administering the HI program and the provisions of the Internal Revenue Code relating to the collection of contributions. Such administrative expenses, which are paid from the HI trust fund, include expenditures for intermediaries to determine costs of and make payments to providers as well as salaries and expenses of the HCFA.

Advisory Council on Social Security. Prior to the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103-296) on August 15, 1994, the Social Security Act provided for the appointment of an Advisory Council every 4 years to study and review the financial status of the OASDI and Medicare programs. The most recent Advisory Council was appointed on June 9, 1994, and is currently reviewing the financial status of the OASDI program. Under the provisions of Public Law 103-296, this is the last Advisory council to be appointed.

Aged enrollee. An individual, age 65 or over, who is enrolled in the HI program.

Annual balance. The difference between the income rate and the cost rate in a given year.

Assets. Treasury notes and bonds guaranteed by the Federal government and cash held by the trust fund.

Assumptions. Values relating to future trends in certain key factors which affect the balance in the trust funds. Demographic assumptions include fertility, mortality, net immigration, marriage, divorce, retirement patterns, disability incidence and termination rates, and changes in the labor force. Economic assumptions include unemployment, average earnings, inflation, interest rates, and productivity. Three sets of economic assumptions are presented in the Trustees Report:

- (1) The low cost alternative, with relatively rapid economic growth, low inflation, and favorable (from the standpoint of program financing) demographic conditions;
- (2) The intermediate assumptions represent the Trustees' best estimates of likely future economic and demographic conditions; and
- (3) The high cost alternative, with slow economic growth, more rapid inflation, and financially disadvantageous demographic conditions.

See also "Hospital assumptions."

Automatic adjustment provisions. The provisions of section 230 of the Social Security Act that are used each year (except when overruled by law) to increase the annual contribution base.

Average market yield. A computation which is made on all marketable interest-bearing obligations of the United States. It is computed on the basis of market quotations as of the end of the calendar month next preceding the date of such issue.

Baby boom. The period from the end of World War II through the mid-1960s marked by unusually high birth rates.

Base estimate. The updated estimate of the most recent historical year.

Beneficiary. A person enrolled in the HI program. See also "Aged enrollee" and "Disabled enrollee."

Benefit payments. The amounts disbursed for covered services after the deductible and coinsurance amounts have been deducted.

Benefit period. An alternate name for "spell of illness."

Board of Trustees. A Board established by the Social Security Act to oversee the financial operations of the Federal Hospital Insurance Trust Fund. The Board is composed of six members, four of whom serve automatically by virtue of their positions in the Federal government: the Secretary of the Treasury, who is the Managing Trustee, the Secretary of Labor, the Secretary of Health and Human Services, and the Commissioner of Social Security. The other two members are appointed by the President and confirmed by the Senate to serve as public representatives. Stanford G. Ross and David M. Walker began serving 4-year terms on October 2, 1990. They have continued serving through the issuance of this report under the provision of the Social

Appendices

Security Act that allows a public representative whose term has expired to continue in the position until the earlier of the time at which a successor takes office or the Board's next annual report is issued. The Commissioner of Social Security became a member of the Board effective March 31, 1995, under Public Law 103-296, approved August 15, 1994. The Administrator of the HCFA serves as Secretary of the Board of Trustees.

Bond. A certificate of ownership of a specified portion of a debt due by the Federal government to holders, bearing a fixed rate of interest.

Callable. Subject to redemption upon notice, such as a bond.

Case mix index. The average DRG relative weight for all the Medicare admissions.

Cash basis. The costs of the service at the point payment was made rather than when the service was performed.

Certificate of indebtedness. A short-term certificate of ownership of 12 months or less of a specified portion of a debt due by the Federal government to individual holders, bearing a fixed rate of interest.

Coinsurance. See "Hospital coinsurance" and "SNF coinsurance."

Consumer Price Index (CPI). A measure of the average change in prices over time in a fixed group of goods and services. In this report, all references to the CPI relate to the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W).

Contribution base. Annual dollar amount above which earnings in employment covered under the HI program are not taxable. Beginning in 1994, the contribution base is eliminated under HI.

Contribution rate. The percentage of taxable earnings, up to the contribution base, that is paid for the HI tax. Currently, the percentages are 1.45 for employees and employers, each. The self-employed pay 2.9 percent.

Contributions. See "Net contributions."

Cost rate. The ratio of the cost (or outgo, expenditures, or disbursements) of the program on an incurred basis during a given year to the taxable payroll

for the year. In this context, the outgo is defined to exclude benefit payments, and administrative costs for certain uninsured persons, for whom payments are reimbursed from the general fund of the Treasury, and for voluntary enrollees, who pay a premium in order to be enrolled.

Covered earnings. Earnings in employment covered by the HI program.

Covered employment. All employment and self-employment creditable for Social Security purposes. Almost every kind of employment and self-employment is covered under the program. In a few employment situations, for example, religious orders under a vow of poverty, foreign affiliates of American employers, or State and local governments, coverage must be elected by the employer. However, effective July 1991, coverage is mandatory for State and local employees who are not participating in a public employee retirement system. All new State and local employees have been covered since April 1986. In a few situations, for example, ministers or self-employed members of certain religious groups, workers can opt out of coverage. Covered employment for HI includes all Federal employees (whereas covered employment for OASDI includes some, but not all, Federal employees).

Covered services. Services for which HI pays, as defined and limited by statute. Covered services are provided by hospitals (inpatient care), skilled nursing facilities, home health agencies, and hospices.

Covered worker. A person who has earnings creditable for Social Security purposes on the basis of services for wages in covered employment and/or on the basis of income from covered self-employment. The number of HI covered workers is slightly larger than the number of OASDI covered workers because of different coverage status for Federal employment. See "Covered employment."

Deductible. See "Inpatient hospital deductible."

Deemed wage credit. See "Non-contributory or deemed wage credits."

Demographic assumptions. See "Assumptions."

Diagnosis-related groups (DRGs). A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee

Appendices

for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Disability. For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers age 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled-worker cash benefit. An additional 24 months is necessary to qualify for benefits under Medicare.

Disability Insurance (DI). See "Old-Age, Survivors, and Disability Insurance (OASDI)."

Disabled enrollee. An individual under age 65 who has been entitled to disability benefits under Title II of the Social Security Act or the railroad retirement system for at least 2 years and who is enrolled in the HI program.

DRG Coding. The DRG categories used by hospitals on discharge billing. See also "Diagnosis-related groups (DRGs)."

Earnings. Unless otherwise qualified, all wages from employment and net earnings from self-employment, whether or not taxable or covered.

Economic assumptions. See "Assumptions."

End-stage renal disease (ESRD). Permanent kidney failure.

Excess wages. Wages in excess of the contribution base on which a worker initially pays taxes (usually as a result of working for more than one employer during a year). Employee taxes on excess wages are refunded to affected employees, while the employer taxes are not refunded.

Extended care services. In the context of this report, an alternate name for "skilled nursing facility services."

Federal Insurance Contributions Act (FICA). Provision authorizing taxes on the wages of employed persons to provide for the OASDI and HI programs. The tax is paid in equal amounts by covered workers and their employers.

Financial interchange. Provisions of the Railroad Retirement Act providing for transfers between the trust funds and the Social Security Equivalent Benefit Account of the Railroad Retirement program in order to place each trust fund in the same position as if railroad employment had always been covered under Social Security.

Fiscal year (FY). The accounting year of the United States Government. Since 1976, each fiscal year has begun October 1 of the prior calendar year and ended the following September 30. For example, fiscal year 1995 began October 1, 1994 and will end September 30, 1995.

Fixed capital assets. The net worth of facilities and other resources.

General fund of the Treasury. Funds held by the Treasury of the United States, other than revenue collected for a specific purpose (such as HI) and maintained in a separate account for that purpose. The majority of this fund is derived from individual and business income taxes.

General revenue. Income to the HI trust fund from the general fund of the Treasury. Only a very small percentage of total HI trust fund income each year is attributable to general revenue.

Gramm-Rudman-Hollings Act. The Balanced Budget and Emergency Deficit Control Act of 1985.

Gross Domestic Product (GDP). The total dollar value of all goods and services produced in a year in the United States, regardless of who supplies the labor or property.

High cost alternative. See "Assumptions."

Home health agency (HHA). A public agency or private organization which is primarily engaged in providing skilled nursing services, other therapeutic services, such as physical, occupational, or speech therapy, and home health aide services, in the home.

Hospice. A provider of care for the terminally ill; delivered services generally include home health care, nursing care, physician services, medical supplies, and short-term inpatient hospital care.

Hospital assumptions. These include differentials between hospital labor and non-labor indices compared to general economy labor and non-labor indices, rates of admission incidence, the trend toward treating less complicated cases in outpatient settings, and continued improvement in DRG coding, etc.

Hospital coinsurance. For the 61st through 90th day of hospitalization in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-fourth of the inpatient hospital deductible; for lifetime reserve days, a daily amount for which the beneficiary is responsible, equal to one-half of the inpatient hospital deductible (see "Lifetime reserve days").

Hospital input price index. An alternate name for "hospital market basket."

Hospital Insurance (HI). The Medicare program which pays for specified inpatient hospital services, posthospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.

Hospital market basket. The cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services.

Income rate. The ratio of income from tax revenues on an incurred basis (payroll tax contributions and income from the taxation of OASDI benefits) to the HI taxable payroll for the year.

Incurred basis. The costs based on when the service was performed rather than when the payment was made.

Inpatient hospital deductible. An amount of money which is deducted from the amount payable by Medicare Part A for inpatient hospital services furnished to a beneficiary during a spell of illness.

Inpatient hospital services. These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Interest. A payment for the use of money during a specified period.

Interfund borrowing. The borrowing of assets by a trust fund (OASI, DI, HI or SMI) from another of the trust funds when one of the funds is in danger of exhaustion.

Intermediary. A private or public organization, under contract to the HCFA, to determine costs of and make payments to providers for HI and certain SMI services.

Intermediate assumptions. See "Assumptions."

Lifetime reserve days. Under HI, there are 60 lifetime reserve days per beneficiary which the beneficiary may opt to use when regular inpatient hospital benefits are exhausted. The beneficiary pays one-half of the inpatient hospital deductible for each lifetime reserve day used.

Long-range. The next 75 years.

Low cost alternative. See "Assumptions."

Market basket. See "hospital market basket."

Maximum taxable amount of annual earnings. See "Contribution base."

Medicare. A nationwide, federally administered health insurance program authorized in 1965 to cover the cost of hospitalization, medical care, and some related services for most people over age 65. In 1972 coverage was extended to people receiving Social Security Disability Insurance payments for 2 years, and people with ESRD. Medicare consists of two separate but coordinated programs -- Part A (Hospital Insurance, HI) and Part B (Supplementary Medical Insurance, SMI). Almost all persons aged 65 and over or disabled entitled to HI are eligible to enroll in the SMI program on a voluntary basis by paying a monthly premium. Health insurance protection is available to Medicare beneficiaries without regard to income.

Military service wage credits. Credits recognizing that military personnel receive other cash payments and wages in kind (such as food and shelter) in addition to their basic pay. Noncontributory wage credits of \$160 are provided for each month of active military service from September 16, 1940, through December 31, 1956. For years after 1956, the basic pay of military personnel is covered under the Social Security program on a contributory basis. Noncontributory wage credits of \$300 for each calendar quarter in which a person receives pay for military service from January 1957 through December 1977 are granted in addition to contributory credits for basic pay. Deemed wage credits of \$100 are granted for each \$300 of military wages in years after 1977. (The maximum credits allowed in any calendar year are

Appendices

\$1,200.) (See also "Quinquennial military service determinations and adjustments.")

Modified average-cost method. Under this system of calculating summary measures, the actuarial balance is defined as the difference between the arithmetic means of the annual cost rates and the annual income rates, with an adjustment included to account for the offsets to cost that are due to (1) the starting trust fund balance and (2) interest earned on the trust fund.

Net contributions. The appropriation of employment taxes, less refunds of employment taxes, and deposits arising from State agreements.

Non-contributory or deemed wage credits. Wages and wages in kind that were not subject to the HI tax but that are deemed as having been. This is done for the purposes of (1) determining HI program eligibility for individuals who might not be eligible for HI coverage without payment of premium were it not for the deemed wage credits and (2) calculating reimbursement due the HI trust fund from the general fund of the Treasury. The first purpose applies in the case of providing coverage to persons during the transitional periods when the HI program began and when it was expanded to cover Federal employees; both purposes apply in the cases of military service wage credits (see "Military service wage credits" and "Quinquennial military service determinations and adjustments") and deemed wage credits granted for the internment of persons of Japanese ancestry during World War II.

Old-Age, Survivors, and Disability Insurance (OASDI). The Social Security programs which pay for (1) monthly cash benefits to retired-worker (old-age) beneficiaries and their spouses and children and to survivors of deceased insured workers (OASI) and (2) monthly cash benefits to disabled-worker beneficiaries and their spouses and children and for providing rehabilitation services to the disabled (DI).

Part A. The Medicare Hospital Insurance program.

Part A premium. A monthly premium paid by individuals who wish for and are entitled to voluntary enrollment in the Medicare HI program. These individuals are those who are age 65 and older who are uninsured for social security or railroad retirement and do not otherwise meet the requirements for entitlement to Part A. In addition, disabled individuals who have exhausted other entitlement are qualified. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act,

continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).

Part B. The Medicare Supplementary Medical Insurance program.

Participating hospitals. Those hospitals who participate in the Medicare program.

Pay-as-you-go financing. A financing scheme where taxes are scheduled to produce just as much income as required to pay current benefits, with trust fund assets built up only to the extent needed to prevent exhaustion of the fund by random economic fluctuations.

Payroll taxes. Taxes levied on the gross wages of workers.

Peer Review Organization (PRO). A group of practicing physicians and other health care professionals, paid by the federal government, to review the care given to Medicare patients.

Present value. The present value of a future stream of payments is the lump-sum amount that, if invested today, together with interest earnings would be just enough to meet each of the payments as they fell due. At the time of the last payment, the invested fund would be exactly zero.

Professional Standards Review Organization (PSRO). The predecessor of the Peer Review Organization.

Projection error. Degree of variation between estimated and actual amounts.

Prospective Payment Assessment Commission (ProPAC). A commission established by the Social Security Amendments of 1983 to review and recommend the appropriate percentage changes which should be effected for payments for inpatient hospital discharges each fiscal year beginning with fiscal year 1986. Furthermore, the ProPAC is expected to study and make recommendations regarding existing reimbursement policy for each fiscal year.

Prospective payment system (PPS). A method of reimbursement for hospitals which was implemented effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment

is made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs).

Provider. Any organization, institution, or individual who provides health care services to Medicare beneficiaries. Hospitals (inpatient services), skilled nursing facilities, home health agencies, and hospices are the providers of services covered under Medicare Part A.

Proxy. An index of known values that likely approximates an index for which values are unavailable. The proxy is used as a "stand-in" for the unavailable index.

Quinquennial military service determination and adjustments. Prior to the Social Security Amendments of 1983, quinquennial determinations (i.e., estimates made once every 5 years) were made of the costs arising from the granting of deemed wage credits for military service prior to 1957; annual reimbursements were made from the general fund of the Treasury to the HI trust fund for these costs. The Social Security Amendments of 1983 provided for (1) a lump-sum transfer in 1983 for (a) the costs arising from the pre-1957 wage credits and (b) the HI taxes on the deemed wage credits for military service for 1966 through 1983, inclusive; (2) quinquennial adjustments to the pre-1957 portion of the 1983 lump-sum transfer; (3) HI taxes on military deemed wage credits for 1984 and later to be credited to the fund on July 1 of each year; and (4) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on military deemed wage credits.

Railroad retirement. A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Real-wage differential. The difference between the percentage increases, before rounding, in (1) the average annual wage in covered employment, and (2) the average annual Consumer Price Index.

Reasonable cost basis. The calculation to determine the reasonable cost incurred by individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by a health insurance program.

Self-employment. Operation of a trade or business by an individual or by a partnership in which an individual is a member.

Self-Employment Contributions Act (SECA). Provision authorizing taxes on the net income of most self-employed persons to provide for the OASDI and HI programs.

Sequester. The reduction of funds to be used for benefits or administrative costs from a Federal account based on the requirements specified in the Gramm-Rudmann-Hollings Act.

Short-range. The next 10 years.

Skilled nursing facility (SNF). An institution which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or engaged in rehabilitation of injured, disabled, or sick persons.

SNF coinsurance. For the 21st through 100th day of extended care services in a benefit period, a daily amount for which the beneficiary is responsible, equal to 1/8 of the inpatient hospital deductible.

Social Security Act. Public Law 74-271, enacted August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, of which four have been repealed. The HI and SMI programs are authorized by Title XVIII of the Social Security Act.

Special public-debt obligation. Securities of the United States Government issued exclusively to the OASI, DI, HI, and SMI trust funds and other Federal trust funds. Section 1817(c) of the Social Security Act provides that the public-debt obligations issued for purchase by the HI trust fund shall have maturities fixed with due regard for the needs of the funds. The usual practice in the past has been to spread the holdings of special issues, as of each June 30, so that the amounts maturing in each of the next 15 years are approximately equal. Special public-debt obligations are redeemable at par at any time.

Spell of illness. A period of consecutive days beginning with the first day on which a beneficiary is furnished inpatient hospital or extended care services and ending with the close of the first period of 60 consecutive days thereafter in which the beneficiary is in neither a hospital or skilled nursing facility.

Appendices

Summarized cost rate. The ratio of the present value of expenditures to the present value of the taxable payroll for the years in a given period. In this context, the expenditures are on an incurred basis and exclude costs for certain uninsured persons, for whom payments are reimbursed from the general fund of the Treasury, and for voluntary enrollees, who pay a premium in order to be enrolled. The summarized cost rate includes the cost of reaching and maintaining a "target" trust fund level, or contingency fund ratio. Because a trust fund level of about one year's expenditures is considered to be an adequate reserve for unforeseen contingencies, the targeted contingency fund ratio used in determining summarized cost rates is 100 percent of annual expenditures. Accordingly, the summarized cost rate is equal to the ratio of (a) the sum of the present value of the outgo during the period plus the present value of the targeted ending trust fund level plus the beginning trust fund level, to (b) the present value of the taxable payroll during the period.

Summarized income rate. The ratio of (a) the present value of the tax revenues incurred during a given period (from both payroll taxes and taxation of OASDI benefits) to (b) the present value of the taxable payroll for the years in the period.

Supplementary Medical Insurance (SMI). The Medicare program which pays for a portion of the costs of physician's services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals. Also known as Medicare Part B.

Taxable earnings. Taxable wages and/or self-employment income under the prevailing annual maximum taxable limit.

Taxable payroll. A weighted average of taxable wages and taxable self-employment income. When multiplied by the combined employee-employer tax rate, it yields the total amount of taxes incurred by employees, employers, and the self-employed for work during the period.

Taxable self-employment income. Net earnings from self-employment, generally above \$400 and below the annual maximum taxable amount for a calendar or other taxable year, less any taxable wages in the same taxable year.

Taxable wages. Wages paid for services rendered in covered employment up to the annual maximum taxable amount.

Taxation of benefits. Beginning in 1994, up to 85 percent of an individual's or a couple's OASDI benefits are potentially subject to Federal income taxation under certain circumstances. The revenue derived from taxation of benefits in excess of 50 percent, up to 85 percent, is allocated to the HI trust fund.

Taxes. See "Contributions."

Test of Actuarial Status. The overall test of actuarial status for the HI program, which includes a test of Short-Range Financial Adequacy, and a test of Long-Range Close Actuarial Balance.

Test of Long-Range Close Actuarial Balance. Summarized income rates and cost rates are calculated for each of 65 valuation periods within the full 75-year long-range projection period under the intermediate assumptions. The first of these periods consists of the next 10 years. Each succeeding period becomes longer by 1 year, culminating with the period consisting of the next 75 years. The long-range test is met if, for each of the 65 time periods, the actuarial balance is not less than zero or is negative by, at most, a specified percentage of the summarized cost rate for the same time period. The percentage allowed for a negative actuarial balance is 5 percent for the full 75-year period and is reduced uniformly for shorter periods, approaching zero as the duration of the time periods approaches the first 10 years. The criterion for meeting the test is less stringent for the longer periods in recognition of the greater uncertainty associated with estimates for more distant years.

Test of Short-Range Financial Adequacy. The conditions required to meet this test are as follows: If the trust fund ratio for a fund exceeds 100 percent at the beginning of the projection period, then it must be projected to remain at or above 100 percent throughout the 10-year projection period; alternatively, if the fund ratio is initially less than 100 percent, it must be projected to reach a level of at least 100 percent within 5 years (and not be depleted at any time during this period) and then remain at or above 100 percent throughout the remainder of the 10-year period. This test is applied to trust fund projections made under the intermediate assumptions.

Trust fund. Separate accounts in the United States Treasury mandated by Congress whose assets may only be used for a specified purpose. For the HI trust fund, monies not withdrawn for current benefit payments and

Appendices

administrative expenses are invested in interest-bearing Federal securities, as required by law; the interest earned is also deposited in the trust fund.

Trust fund ratio. A short-range measure of the adequacy of the trust fund level; defined as the assets at the beginning of the year expressed as a percentage of the outgo during the year.

Unit input intensity allowance. The amount added to or subtracted from the hospital input price index to yield the PPS update factor.

Valuation period. A period of years which is considered as a unit for purposes of calculating the status of a trust fund.

Voluntary enrollee. Certain individuals aged 65 or older or disabled, who are not otherwise entitled to Medicare who opt to obtain coverage under Part A by paying a monthly premium.

Year of exhaustion. The first year in which a trust fund is unable to pay benefits when due because the assets of the fund are exhausted.

F. STATEMENT OF ACTUARIAL OPINION

It is my opinion that (1) the techniques and methodology used herein to evaluate the financial status of the Federal Hospital Insurance Trust Fund are based upon sound principles of actuarial practice and are generally accepted within the actuarial profession; and (2) the assumptions used and the resulting actuarial estimates are, in the aggregate, reasonable for the purpose of evaluating the financial status of the trust fund, taking into consideration the experience and expectations of the program.

Although the assumptions used are reasonable, much of the available evidence suggests that they may not be optimal. In particular, the likelihood of a future result that is more adverse than the intermediate projection may exceed the likelihood of a more favorable result. Similarly, an outcome more adverse than the high cost projection may be more probable than one that is better than the low cost projection.

The future cost of the hospital insurance program is very uncertain and reasonable people can disagree concerning the most probable economic and demographic trends. For these reasons, projections are shown in this report under three different sets of assumptions intended to illustrate a broad range of possible outcomes. Readers are cautioned not to focus solely on just one set of assumptions but rather to recognize that any result within the range shown can reasonably be expected to occur.

As noted in this report, the assets of the hospital insurance trust fund are projected to be depleted within 11 years under all three sets of assumptions. Thus, regardless of the specific assumptions used, the need for prompt attention to the fund's financial imbalance is apparent.



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